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Contributors to this Issue



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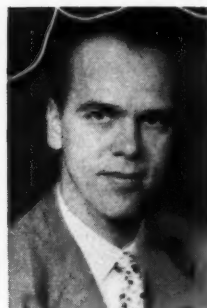
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January 31	Mt. Carmel Mercy Hospital Clinic Day	Detroit
February 8	Jackson County Medical Society's Clinic Day	Jackson
March 14-15-16	MICHIGAN POSTGRADUATE CLINICAL INSTITUTE	Detroit
March 17	SECOND ANNUAL MICHIGAN HEART DAY	Detroit
Spring	MSMS Postgraduate Courses	Extramural State-wide
April 3	Calhoun County Medical Society's Clinic Day	Battle Creek
April 4	SECOND MICHIGAN INDUSTRIAL HEALTH DAY	Detroit
April 18	Genesee County Medical Society's Cancer Day	Flint
April	Highland Park Physicians Club Clinic	Highland Park
May 3	Ingham County Medical Society's Clinic Day	Lansing
May 9	Wayne University College of Medicine Alumni Association Clinic Day and Reunion	Detroit
May 22	Bon Secours Hospital Clinic Day	Grosse Pointe
June	St. Clair County Medical Society's Clinic Day	St. Clair
June	Upper Peninsula Medical Society Annual Meeting	
July 26-27	Annual Collier-Penberthy Medical-Surgical Conference (sponsored by Grand Traverse - Leelanau - Benzie County Medical Society)	Traverse City
Sept. 26-27-28	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION	Grand Rapids
October 13	Third Michigan Cancer Conference	East Lansing
Autumn	MSMS Postgraduate Courses	Extramural State-wide
Oct. or Nov.	American Academy of General Practice of Wayne County	Detroit
November 7	Clara Elizabeth Fund Lectures (sponsored by Genesee County Medical Society and the Clara Elizabeth Fund for Maternal Health)	Flint

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

FEATURED SUBJECTS FOR 1951

THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY will be dedicated in 1951 to the following topics:

January:	Michigan Postgraduate Clinical Institute (March 14-16, in Detroit)
February:	Easter Seals
March:	Atomic Number—with Cancer Control tied in.
April:	Public Relations—and Silver Anniversary of Woman's Auxiliary to MSMS
May:	Michigan's Foremost Family Physician—and Salute to the AMA
June:	Michigan Medical Service
July:	Roster Number
August:	Annual Session Number (September 26-28, in Grand Rapids)
September:	Arthritis and Rheumatism
October:	Michigan Foundation for Medical and Health Education, Inc.
November:	Michigan Health Council
December:	Heart Disease and Rheumatic Fever Control

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of November 8, 1950

- Monthly financial reports, including detailed breakdown of the Public Education Account and of the Public Education Reserve Account, were presented, studied in detail, and approved. Bills payable for the current month were presented, approved, and payment was authorized.
- Color insert in JMSMS. The Editor was authorized to publish a color insert in four issues of JMSMS in 1951, with all copy to be supervised by the Editor; two pages are to be devoted to the work of the MSMS Public Relations Department and two pages to a progress report of Michigan Medical Service. Times of insertion are left to the discretion of the Editor.
- The fiftieth year of publishing THE JOURNAL of the Michigan State Medical Society. The recommendation of Editor Haughey that some special notation be placed on the covers of all 1951 Numbers, to indicate the Golden Anniversary of THE JOURNAL, was approved.
- The President's monthly report was given, including the appointment of the following personnel as the Committee of Seven to Study Basic

(Continued on Page 14)

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1. Nesbit, R. M., and Glickman, S. I.: J. Michigan State M. Soc.
46:664, 1947.

2. Dodson, A. I.: West Virginia M.J. 45:1, 1949.

3. Seneca, H.; Henderson, E., and Harvey, M.: J. Urol. 61:1105, 1949.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

(Continued from Page 12)

Science Law, following instructions of the House of Delegates: J. Duane Miller, M.D., Grand Rapids, Chairman; W. B. Harm, M.D., Detroit; J. Joseph Herbert, LL.B., Manistique; J. E. Livesay, M.D., Flint; J. H. Schlemer, M.D., Detroit; E. D. Spalding, M.D., Detroit, and D. B. Wiley, M.D., Utica.

The President reported on action taken by the American College of Surgeons re its hospital standardization program which it will continue to maintain with perhaps advisory representation from the American Medical Association, the American College of Physicians, and the American Hospital Association. Details are now being discussed.

- Official MSMS representatives to attend annual meeting of the Michigan Public Health Association and of the Michigan Health Officers Association in Grand Rapids on November 29, 30-December 1 were selected.
- President-Elect O. O. Beck, M.D., suggested a more fitting name and more exact definition of the scope of work handled by the State and County Mediation Committees; this was referred to the Legal Counsel for opinion.
- Associate Fellowship in the A.M.A.: The name of Wilfrid Haughey, M.D., Battle Creek, was nominated for this honor.
- Fifth Michigan Postgraduate Clinical Institute, Detroit, March 14-15-16, 1951: The Press Relations Committee was appointed, as follows: R. A. Johnson, M.D., Detroit, Chairman; William Bromme, M.D., Detroit; H. F. Dibble, M.D., Detroit; K. P. Hodges, M.D., Lansing; Arch Walls, M.D., Detroit, and J. A. Witter, M.D., Detroit.
- The Chairman of the MSMS Industrial Health Committee (M. R. Burnell, M.D., Detroit) was authorized to attend the Eleventh Annual Congress on Industrial Health (sponsored by the AMA) in Atlanta, Ga., February 26-27, 1951.
- Lunette I. Powers, M.D., Muskegon, was selected as MSMS nominee for the AMA General Practice Award, and also was chosen as Michigan's Foremost Family Physician for the year 1950.
- The tentative program for the 1951 Annual

County Secretaries-Public Relations Conference, scheduled for Detroit, January 21, 1951, was presented and approved.

- H. W. Porter, M.D., Jackson, Chairman of the MSMS Cancer Control Committee, presented a verbal report on recent activities and the aims of this Committee, to which he recently appointed 17 sub-committees.
- The Public Relations Counsel's monthly report included progress on the Good Citizenship Campaign; the Michigan Rural Health Survey; Sex Deviates Legislation; MSMS movies "To Your Health" shown in 210 theaters and "Lucky Junior" in 241 theaters; broadcasts by MSMS, every three months, similar to that presented on November 1 by Secretary L. Fernald Foster, M.D., were authorized for 1951; co-operation with the Medical Arts Pharmacy of Detroit in its Sunday afternoon television program over WXYZ-TV, was authorized; an MSMS exhibit at the 1951 Michigan State Fair was authorized; report on the Michigan Rural Health Conference of October 20-21 was presented; an inexpensive motion picture, stressing the MSMS campaign to secure more doctors of medicine for public service, was authorized for 1951.
- Michigan Health Commissioner A. E. Heustis, M.D., was present to discuss: (a) new birth certificates and wording thereof; (b) reporting of communicable diseases; (c) blood typing program in Jackson, Michigan; and (d) child health and maternal health appropriations (as a result of H.R. 6000).
- The following Committee reports were given consideration: (a) Cancer Control Committee, meeting of October 18; (b) Rheumatic Fever Control Committee, meeting of October 25; (c) Advisory Committee to National Foundation for Infantile Paralysis, meeting of October 26; (d) Committee on Atomic and Allied Procedures, meeting of November 3, and (e) Maternal Health Committee, meeting of November 7.

HOSPITAL STANDARDIZATION PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS

So much misinformation about the Hospital Standardization Program of the American College of Surgeons has been circulated, both in the medical press and by word of mouth, that the

(Continued on Page 16)

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Dryco assures ample protein intake while its low fat ratio and moderate carbohydrate content minimize digestive disturbances.

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Available at pharmacies in 1 and 2½ lb. cans.

*Pitt, C.K.: *The Art and Science of Artificial Infant Feeding*, J.M. Asso. Ala. 19:101 (Oct.) 1949.

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HOSPITAL STANDARDIZATION

(Continued from Page 14)

facts of the situation should be presented to the profession.

It has been no secret that financing this program has given the Regents concern for some time. The increasing number of hospitals requesting approval and the decreasing value of the dollar have created a serious problem. However, at no time have the Regents decided to abandon the program, and never have they made any overtures to any other organization regarding its disposal.

In July of this year, the Regents received a proposal from the American Hospital Association that the latter assume and finance the Hospital Standardization Program. A Committee of the College was appointed to meet with representatives of the A.H.A. for the sole purpose of phrasing this proposal in specific terms. It cannot be emphasized too strongly that the function of, and instructions to, this committee were limited to this purpose.

The Regents considered this proposal for the first time on August 4, 1950. It was not accepted by the College; and the Regents immediately acted to arrange for conferences with representatives of the A.M.A., the American College of Physicians, and the A.H.A. Statements that the Regents first agreed to the proposal and later reversed this decision are wholly erroneous.

Three such conferences have been held. Divergence of points of view has diminished but no agreement has yet been reached. Hope that ultimately a satisfactory agreement can be reached has increased with each conference.

The Regents have every intention of continuing the Hospital Standardization Program, upon an expanded scale and even with deficit financing, until a solution can be found which is agreeable to the majority of the profession and which is, above all, in the best interests of the public.—American College of Surgeons, November 27, 1950.

MSMS CANCER COMMITTEE OFFICE MOVED TO JACKSON

The Cancer Control Committee Office was moved from Ann Arbor to 428 Wildwood Ave., Jackson, Michigan, on November 10. The telephone number is Jackson 20652. Both the Com-

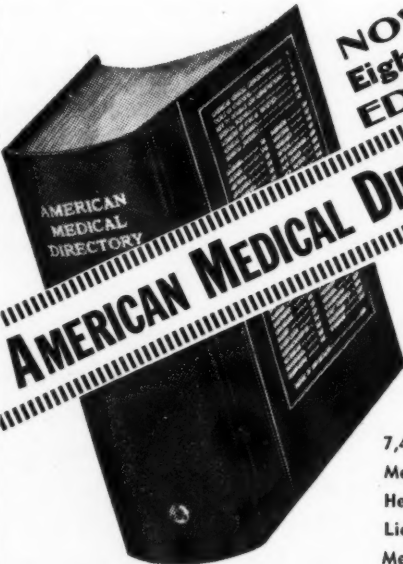
mittee Chairman, Horace Wray Porter, M.D., and the Secretary, Frank L. Rector, M.D., may be reached at the new address in Jackson.

BY-LAWS AMENDED RE LIFE MEMBERSHIP

The House of Delegates of the Michigan State Medical Society, at its Detroit Annual Session of September 18-19, 1950, amended the MSMS By-Laws, Chapter 5, Section 7 re Life Membership, by deleting the word "consecutive" between the words "twenty-five" and "years."

This Section now reads:

"Chapter 5, Section 7, Life Member—A Doctor of Medicine who has attained the age of seventy years and maintained an active membership in good standing for twenty-five years in this State Society may, upon his application, and recommendation of his component County Society, be transferred to the Life Members' Roster. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for such transfer shall be accompanied by certification by The Secretary of The State Society as to years of membership in good standing. He shall be entitled to receive THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY at such rates as The Council may determine."



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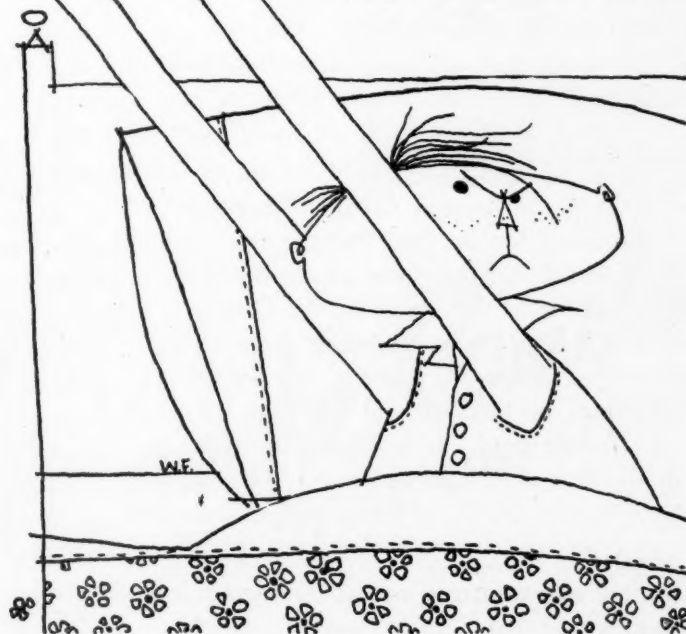
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Cancer Comment

AMERICAN CANCER SOCIETY PROFESSIONAL EDUCATION PROGRAM

The Professional Education program of the American Cancer Society has been expanded during the past year to provide some form of educational service to practically all physicians in the United States.

In the field of scientific cancer literature the Journal "CANCER" has been published bi-monthly for the past three years, and is devoted largely to clinical research. Each issue contains a number of original articles in the cancer field, also a section of abstracts of world cancer literature.

To provide a more usable educational medium, a new journal "CA—A Bulletin of Cancer Progress" has been developed. This publication will appear bi-monthly and is of pocket size. This illustrated bulletin is written for the general practitioner and contains one or two original articles on cancer problems frequently encountered in the physician's office practice. A clinico-pathological conference report is included in each issue, as are abstracts of current cancer literature. This bulletin is intended for easy reading and wide distribution.

Another publication for the medical profession is a series of monographs sent to 173,000 physicians in the United States and Canada. Each issue deals quite thoroughly with one subject. The five issues so far distributed to physicians deal with genito-urinary, lung, breast, head and neck, and cancer in general. A special issue on mouth cancer has been distributed to dentists.

A bibliography on "Cancer Current Literature" has been published for the past three years. This is a monthly compilation of world cancer literature classified according to the system of the Quarterly Cumulative Index Medicus including cross references and author index. This is the only available up-to-date index of medical and scientific literature in the cancer field. It will be sent without charge by the American Cancer Society, 47 Beaver Street, New York 4, N. Y., to any physician asking for it.

The Society also prepares topical bibliographies for physicians and has a large reprint collection available for lending purposes. A collection of more than 400 lantern slides, both black and

white and kodachrome, are also available for loan. The Society's library contains bound copies of all important books in the cancer field.

Exhibits on various aspects of cancer suitable for professional meetings are also available.

Two new motion picture films on breast cancer have been developed recently. One deals with breast cancer and its diagnosis and is intended for professional use. The other, entitled "Self Examination of the Breast" is intended for lay showing and teaches women to examine their own breasts at regular intervals. A film on cancer for nurses has recently been made available.

The Cancer Society annually awards clinical fellowships to approximately 70 physicians. These fellowships are served in 36 institutions and cover surgery, radiology, pathology, gynecology, urology, internal medicine, and general practice. Eleven fellowships in exfoliative cytology have also been awarded.

In addition to the professional services available directly from the Society's headquarters, it supports the research program of the Committee on Growth of the National Research Council. Some 250 research projects entailing the annual expenditure of more than three million dollars are currently in operation. These projects deal with the physical, chemical, biological, and other scientific aspects of growth and are focussed on the general problem of an understanding of the intimate composition and functioning of the living cell.

The facilities and services described above are freely available to all Michigan physicians through the two state divisions of the American Cancer Society or the Cancer Control Committee of the Michigan State Medical Society. With other sources of professional education through state and national medical journals and through articles in specialty journals and other scientific literature, all physicians have access to an abundance of cancer education literature which, if carefully studied, will enable them to render an increasingly better service to their cancer patients.

One of the current objectives of the Cancer Control Committee is to obtain more instruction of undergraduate medical students in cancer detection examination methods. In time, this should provide a service to meet all the public's needs.

How mild can a cigarette be?

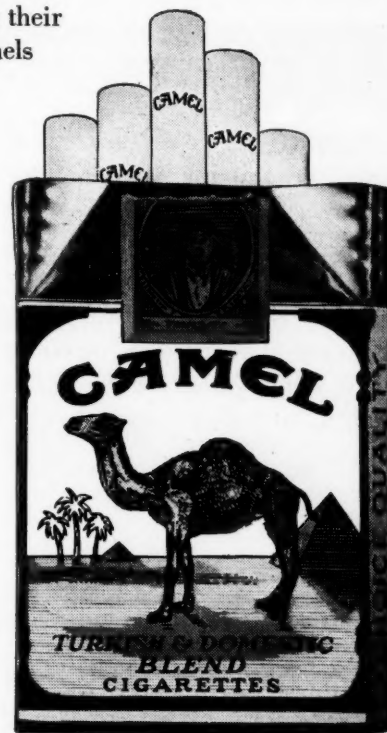
● Every day, more and more smokers—and among them many, many doctors—are discovering for themselves just how mild a cigarette can be. They're making their own 30-Day Camel Mildness Tests—smoking Camels regularly for 30 days.

It's a sensible cigarette test. As a doctor, you know there can be no valid conclusion drawn from a one puff comparison—from a trick test that calls for hasty decisions. The Camel 30-Day Test asks you to make a day after day, pack after pack comparison.

If you are not already a Camel smoker, why not try this test? Judge Camel mildness and the rich, full flavor of Camel's choice tobaccos in your own "T-Zone"—the real proving ground for a cigarette. See if the Camel 30-Day Test doesn't give you the most enjoyment you've ever had from smoking!

Make your own 30-Day Camel Mildness Test in your own "T-Zone"—

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Admission Policy at University of Michigan

For some time, The Council of the Michigan State Medical Society has felt the need for disseminating information to MSMS members relative to the admission policy of the University of Michigan Hospital.

The University Hospital authorities, at the Council's request, have developed a very clear statement of procedure for the admission of in-patients and out-patients to the U. of M. Hospital. These concise instructions follow:

Hospitalization

Advance reservation for hospitalization may be made for patients you feel require it. Ambulatory patients will be seen first in the Out-Patient Clinic for confirmation.

Patients will be asked to make an advance deposit, the amount based on the estimated length of stay.

Since the University Hospital receives no appropriations from tax funds for its operations and therefore is entirely self-supporting, it is absolutely necessary that patients make financial arrangements for payment of clinic fees or cost of hospitalization before coming to the hospital.

Patients unable to pay should be referred for financial assistance to your local Social Welfare Department.

Out-Patient Clinics

Hours.—8:00 A.M. to 5:00 P.M., except Saturdays, Sundays, and New Year's, Memorial, Independence, and Labor Day, Thanksgiving and Christmas holidays.

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*Neurosurgery
Obstetrics
Ophthalmology
*Oral Surgery
*Orthopedics
Otorhinolaryngology
Pediatrics and Communicable Diseases
Thoracic Surgery
Tuberculosis
*Urology

Appointments.—All patients require referral by a physician and except for clinics marked with an asterisk all require prior appointment. Referral by letter is preferred, but appointments can be made by a telephone call to the Appointment Clerk. Patients should arrive one hour before appointment to complete registration.

Fees.—A flat fee, the amount of which is dependent on the patient's financial status, is payable on registration. This fee includes a 70 mm. chest photofluorogram, a Kahn test, a hemoglobin determination, and all clinic visits for a period of fifteen days. It does not include other laboratory or x-ray examinations or minor surgical procedures.

A change in bowel habits, which means any variation from what may be considered normal or habitual for the individual in question, is a common symptom of cancer of the rectum and sigmoid.

* * *

Pain is a late symptom of cancer of the rectum and usually does not occur until the lesion infiltrates adjacent organs, becomes obstructive, or is situated so low in the bowel as to involve the anal canal and lie within the grasp of the sphincter muscle.

*No prior appointment required.

"In addition to the relief of hot flashes and other undesirable symptoms (of the climacteric), a feeling of well-being or tonic effect was frequently noted" after administration of "Premarin."

Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being."

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.



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AMA Aid to Medical Schools

Responding to the challenge of President Elmer L. Henderson, M.D., of Louisville, Kentucky, that the medical profession take the initiative in raising private financing for hard-pressed medical schools, rather than seeking federal subsidies for medical education, the American Medical Association, on December 6, 1950, appropriated a half million dollars as the nucleus of a fund to be raised for the aid of medical schools throughout the Nation.

The half million dollar contribution was voted unanimously by the AMA Board of Trustees and was announced by its chairman, Dr. Louis H. Bauer of Hempstead, New York, at a meeting of the Association's House of Delegates.

Dr. Bauer's statement follows:

"The Board of Trustees of the American Medical Association is pleased to announce to the House of Delegates that it has appropriated a half million dollars out of its National Educational Fund, which was raised to defend medical freedom, for the aid and support of medical schools which are in need of additional financing.

"This fund will be given to the medical schools for their unrestricted use in their basic training of future physicians.

"This appropriation to aid the medical schools has been made possible by the widespread public co-operation which the profession has received from the American people in its campaign against Compulsory Health Insurance. The fight against socialized medicine must go on until this issue has been clearly and finally resolved, but the pressure for regimentation of the medical profession has greatly lessened, due to the magnificent public support which we have received.

"The Board of Trustees, therefore, feels that it is keeping faith with the American people, who have given medicine such a splendid vote of confidence, when it contributes this amount to the medical schools of the Nation.

"There is growing public awareness that federal subsidy has come to be a burden, not a bounty, for it is bringing intolerable increases in taxation, and is dangerously increasing federal controls over our institutions and the lives of our people.

"American medicine feels very strongly that it should not seek federal aid for medical schools, until all other means of financing have been exhausted. The Board of Trustees announced its belief that funds for this purpose could be obtained from private sources—and as practical evidence of our sincerity of purpose, this appropriation has been made as the nucleus of a fund which

we hope will be greatly augmented by contributions from many other sources.

"The Board hopes that this action will become a stimulus to other professions, industries, businesses, labor groups and private donors to contribute to this very important cause of protecting and advancing the interests of medical education and the public health.

"The American Medical Association urges all its members to contribute individually to this cause, and we hope that doctors will take the lead in securing contributions from other sources.

"Furthermore, the American Medical Association invites attention to the fact that it has been spending about a quarter of a million dollars a year for many years past to advance medical education through its Council on Medical Education and Hospitals and other departments. This appropriation, voted today, for an entirely new purpose, is in addition to nearly \$285,000 already budgeted for this work during 1951.

"The Nation's medical schools are of the greatest importance to every American citizen and the AMA has had the advancement of their standards as one of its main objectives for over 100 years. The Board of Trustees feels that if all other organizations and individuals will render support of this worthy cause in accordance with their financial ability that not only will the financial security of medical schools be assured, but that their freedom will be protected."

THE CARPENTER LOOKS AT SOCIALIZED MEDICINE

If the day ever comes to America when Uncle Sam usurps the power to dictate to doctors under a health plan, it will be a sad day for carpenters. Adequate housing is still an unsolved problem in this country, especially for the poor. If it is logical to nationalize the medical profession to get more medical service for the poor, it is equally logical to nationalize the home construction industry to get roofs over the heads of the lower income groups.

I do not know much about doctors, but I know quite a bit about carpenters. They are an independent lot. They want to work where and how they please. The first bureaucrat who told a carpenter he had to work in Little Rock when he wanted to work in Lancaster would be gumming his food for lack of teeth. Carpenters want to be free agents; free to work where they want to; free to negotiate the terms of their wages and working conditions; yes, even free to leave the industry and try their luck at something else if the spirit moves them.

They will retain these freedoms only so long as other groups retain theirs. Socialism is like a wolf with a tapeworm; once it starts gnawing, it never can stop. Socialized medicine would only be the first bite out of our free enterprise system; it would not be many years before the carpenters would be feeling the teeth of socialization on the seats of their overalls. Any way you look at it, socialized medicine is no bargain and the carpenters want none of it.—WILLIAM L. HUTCHISON, General President Brotherhood of Carpenters and Joiners, Vice President A.F. of L., Cleveland, Dec. 6, 1950.

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You'll be particularly interested in our large showrooms which display the finest examining room and operating room equipment in actual office layouts . . .

. . . and the very latest equipment for compounding pharmaceutical preparations that features our greatly enlarged laboratories.

The ample parking facilities will make it most convenient for you to visit us, and you will enjoy the same expert attention to your needs that have characterized J. F. Hartz Company service to the medical profession for over 50 years.

The J. F. Hartz Company will continue to provide the Medical profession and its patients the services of a complete prescription pharmacy and truss fitting department at its old location . . . 1529 Broadway, Detroit.

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Editorial Comment

THE FAMILY DOCTOR

It is 3 a.m. Your son is tossing feverishly on his bed. You have tried everything you know, but nothing seems to help. The youngster is wheezing, and darned sick. Your nerves are jumping. Lord, if you could only do something to help. Your own inadequacy taunts you. You sit on the edge of the bed, and your heart is sick when the youngster moans:

"Daddy, it hurts so."

Then the doorbell rings. It's the sweetest sound you ever heard. It's the family doctor. It's 3 a.m., but here he is, looking calm and confident and fresh as a daisy. Fresh as a daisy and as patient as a saint.

The awful weight falls from your shoulders. The doctor is here, and he knows what to do. He goes about it, while you stand back in awe. He does what needs to be done, and within an hour things are looking an awful lot better. And you thank God for the family doctor as thousands have thanked Him before you, and as thousands will thank Him in years to come.

The position of the family doctor is unique. He is a physician, to be sure, and frequently a surgeon as well. But he is also a friend, a counselor, a psychiatrist, sometimes almost a minister. He works himself to death, but he manages, somehow, to keep going.

Medicine today is highly specialized. No man can know everything there is to know about every subject. The family doctor does not pretend he is omnipotent. But he knows the specialists who do know about every unusual condition, and if he feels unqualified to handle a case he will refer it to the proper specialist.

Meanwhile he goes about taking care of most of life's ailments, bringing babies into the world, taking care of them when they are sick, living a rich and full and abundant life and making the world a happier and a brighter place in which to live.

The title "Family Doctor of the Year" has been bestowed on Dean Sherwood Luce, M.D., seventy-four, of Canton, Massachusetts, by the American Medical Association, meeting here. Dr. Luce is to be congratulated. Yet, we feel that he would be

the first to consider that the honor was deserved in equal measure by every family doctor in America.

If it can be said of any man that his name is blessed, it can be said of the family doctor who shows up when a fellow is in real trouble, and who picks up the load at 3 a.m., and carries it.—Editorial, *The Plain Dealer*, Cleveland, Ohio, Dec. 6, 1950.

PROFESSION IN REVOLT

IN LONDON, twenty-six doctors have mounted guard over a hospital, taking turns on watch through day and night to keep the government from seizing their institution.

The doctors maintain that the area where it stands needs a general hospital, which is what they have. The government wants to convert it to purely maternity purposes, which the defenders contend is not nearly so necessary as the kind of place now operating.

To get the issue in perspective, try to name somebody in the County Building whom you would trust with your personal medical requirements and judgments in preference to a group of physicians.

We doubt that you can, or would try to. Asking you to do so is also asking you to subscribe to the practice of socialized medicine.

Of course, if you want socialized medicine, and believe in it as a theory, perhaps you would be willing to oblige with the name of the County Supervisor or City Councilman to whom you go when ill instead of to a doctor.—Editorial, *Detroit Free Press*, December 9, 1950.

SLANDER

Dr. L. F. Foster, secretary of the State Medical Society, called a spade a spade and a liar a liar in a powerful speech Wednesday night over a Detroit radio station.

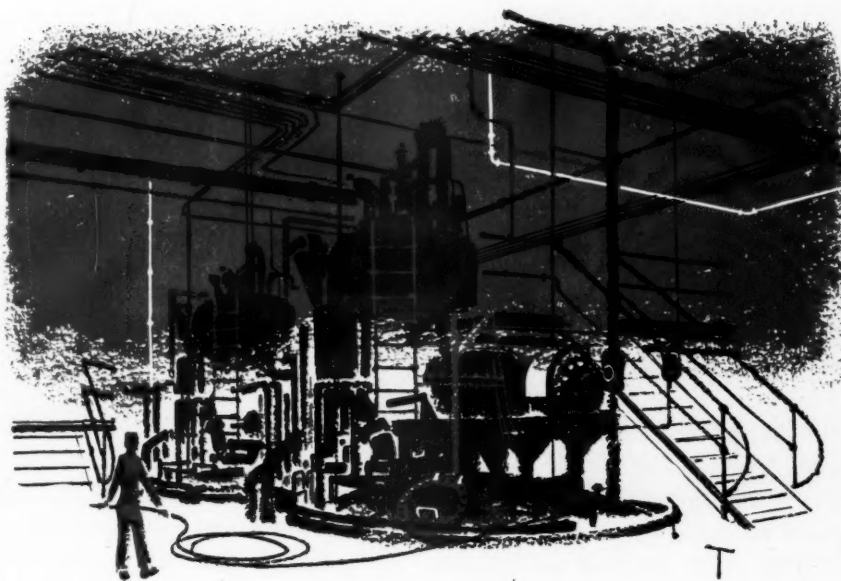
Dr. Foster was indignant, and rightly so, at the false propaganda circulated by those who are advocating federalized medicine after the pattern of Great Britain. He properly pointed out that Oscar Ewing during a long period of time as federal social security administrator used public funds

(Continued on Page 26)

AUREOMYCIN

Lederle

Effective against many bacterial and rickettsial infections, as well as certain protozoal and large viral diseases.



The isolation of crystalline aureomycin from the fermentation mash is an intricate task. It must be done in such a way that inactivation or loss of the antibiotic is minimized. In addition, the removal of impurities must be so complete that the finished product will cause a minimum of undesirable side-reactions. For this purpose, highly specialized technical equipment is employed, in order to effect liquid-solid and liquid-liquid extractions. Vacuum concentration and crystallization

are carried out in glass-lined tanks, to avoid heavy metal contamination. The temperature and degree of vacuum are automatically controlled by means of precision instruments and the purification of the product is carefully followed by laboratory tests.

Aureomycin is now available in a number of convenient forms, for use by mouth and in the eye. New forms of this antibiotic of unsurpassed versatility are constantly being brought out.

*Capsules: Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.*

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

EDITORIAL COMMENT

SLANDER

(Continued from Page 24)

and persons hired with tax money to attack the medical profession and to promote socialism.

Along these same lines Detroit newspapers recently have published an advertisement under the name of the "CIO national health committee" in which doctors are unfairly attacked by untruthful statements.

For example, the advertisement says doctors "fought vaccination against diphtheria and other contagious diseases by public health authorities." That has not been true in Michigan communities where doctors have urged vaccination and encouraged their patients to go to public health officers or school doctors when such service was available. In fact, the records show that it was the Jackson County Medical Society which started a campaign against diphtheria here with free immunization of children in school in 1922—28 years ago!

* * *

The ad says doctors "fought against the reporting of communicable diseases and public health services to control TB." That has not been true in Jackson or elsewhere in Michigan in the modern era.

It says, "they still oppose free diagnostic centers for TB and cancer." That is false. Free tuberculosis diagnostic service for the schools was started here in 1929, inspired by the medical society, and it still continues. The state medical society set up the free diagnostic centers for cancer throughout the state, manned without charge by the best available men. Our Michigan rheumatic fever control, which has been operating with the blessing of the medical society for seven years, is called the best in the United States. Further, as an example of Jackson's own experience the crippled children's clinics here have commanded the services without charge of our best orthopedic surgeons and nurses as well as famed surgeons from the university.

The CIO committee says they, the doctors, "fought the American Red Cross blood bank plan." Jackson knows something about blood

banks, being the pilot city for the nation. Dr. T. E. Schmidt, of Jackson, is credited by the civil defense administration with major credit for success of the project which he long urged. Dr. Schmidt is not paid for his service. Other doctors likewise contributed services as did nurses.

* * *

The Detroit advertisement says, the doctors "fought voluntary insurance plans, until they could no longer stop them." Where does the CIO committee get such misinformation? The Michigan State Medical Society by resolution undertook organization of group health insurance 18 years ago—in 1932. However, it was not until 1939 that the legislature passed the necessary laws to permit such operation. This Blue Cross plan for hospital, surgical and medical insurance insures more than 2,000,000 persons in Michigan; and it was started by doctors before anybody was talking audibly about any form of government medicine.

Further the CIO committee and Oscar Ewing charge doctors with opposing expansion of medical schools. The fact is that the Michigan Medical Association is on record as having appealed to the legislature to expand the teaching and laboratory facilities of the state's two medical schools, the University of Michigan and Wayne University.

Doctors are human beings. Some are greedy, unprincipled and self-centered. But they are the exceptions. You can't make a good man out of a sloth or scoundrel by giving him a medical degree. But the vast majority of doctors live up to the highest standards of human service, and they certainly do not deserve to be libeled and slandered by promoters of socialistic nostrums.—*Jackson Citizen-Patriot*, Nov. 3, 1950.

A digital examination will usually distinguish cancer of the hypopharynx from retropharyngeal abscess; the latter is soft, nonulcerated and hemispheric.

* * *

Obvious cancer is late cancer in the breast.

* * *

Nine-tenths of all breast cancers can be palpated by the physician.



ROUGH HANDS FROM TOO MUCH SCRUBBING?

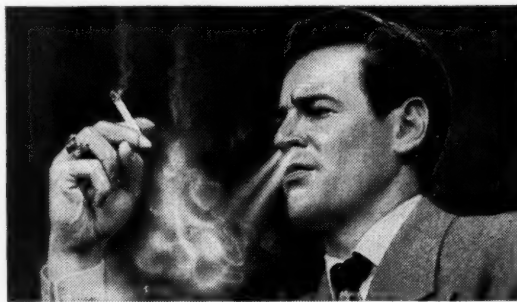
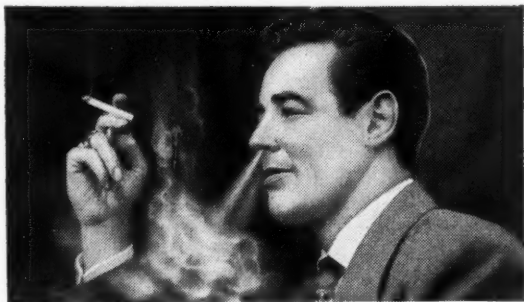
Soothe rough, dry skin with AR-EX Chap Cream. Contains healing ingredient, carbonyl diamide. Aids severely chapped and broken skin. Pleasant to use. Scented or Unscented. Send for sample.

AR-EX COSMETICS, INC., 1036-J W. Van Buren St., Chicago 7, Ill.



**NOW PROOF...in an instant, Doctor,
PHILIP MORRIS are LESS IRRITATING**

Just Make This Simple Test:



1 ... light up a
PHILIP MORRIS
Take a puff—DON'T INHALE. Just
s-l-o-w-l-y let the smoke come through
your nose. Easy, isn't it? AND NOW...

2 ... light up your present brand
DON'T INHALE. Just take a puff and
s-l-o-w-l-y let the smoke come through
your nose. Notice that bite, that sting?
Quite a difference from PHILIP MORRIS!

YES, your own *personal experience* confirms the results of the clinical
and laboratory tests.* With proof so conclusive, would it not be good practice to
suggest PHILIP MORRIS to your patients who smoke?

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc.
100 Park Avenue, New York 17, N. Y.

**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

Political Medicine

LET'S REMEMBER THE SEA GULLS!

We wonder if there isn't something of a moral for the American people in the story of what is happening to the sea gulls up in St. Augustine, now that the shrimp fleet has left that area for Key West.

It seems the sea gulls up that way have forgotten how to catch fish for themselves. For many years they have been depending for their food on the scraps and waste thrown overboard from the shrimping fleet. It was a sort of super welfare state for the birds, and the free dinners made it unnecessary for the gulls to depend on their own talents to secure food.

But, suddenly, the shrimp fleet went away. New and more productive fishing grounds were located off Key West and the shrimp boats deserted St. Augustine.

The sea gulls haven't been able to adjust themselves to the new situation. According to an INS report, the reefs and the shores around St. Augustine are lined with long silent rows of gulls with their dark eyes turned prayerfully out to sea—waiting for the shrimp fleet and the free meals that won't return.

Nature has played the sea gulls a dirty trick. As generation after generation of gulls learned to depend on the shrimp fleet instead of their own resources to obtain food, parent gulls apparently forgot to teach their little ones their age-old methods of catching fish. So today the gulls are starving. They are no different in physical makeup than the sea gulls of Ft. Lauderdale, but whereas our gulls can exist through their own efforts, the gulls of St. Augustine are starving by the hundreds because their welfare state suddenly disappeared and with it went their ability to fend for themselves.

The people of St. Augustine are trying desperately to save the gulls that are left. A city-wide effort is being made to round up table scraps and movie popcorn to tide the birds over until they can once more learn to feed themselves.

But naturalists aren't too sure what will happen. They are puzzled over the apparent complete loss of the sea gulls' natural fishing instincts. Some believe the cycle will be completed without the gulls ever recovering their natural fishing ability.

It's a strange paradox that Nature thus gives us. Here we have some of the most independent creatures of the Universe, who were given marvelous talents to take care of themselves, victimized because they succumbed to the "something for nothing" lure. They became dependent on unnatural conditions to such an extent that parents apparently forgot to teach their offspring how to get along otherwise. Now with the free food gone, the offspring of these indolent parents are paying the penalty.

We wonder if people aren't a great deal like the sea gulls of St. Augustine. We wonder how many Americans have swallowed the idea of the welfare state to the point where they think it is no longer necessary to teach their offspring that the day of government handouts and security for all may sometime draw to a close. And we

wonder then how many Americans may be left like the gulls—puzzled and bewildered because their sustenance has disappeared and they have no resources of their own to fall back on.

Americans don't have to look far to see the sea gull story translated over into human behavior. We have in England a living example of a "something for nothing" theory gobbled up by the people. Like the sea gulls of St. Augustine, the people of Great Britain have accepted unnatural conditions as a substitute for depending upon themselves. The English government is the "shrimp fleet" which provides the people of Britain with food, clothing and shelter. As long as this government is firm and strong and as long as there are shrimp (meaning taxes) enough to keep it in business, the people will be safe.

But let the shrimp be exhausted, as is now happening, then the government must seek new beds. It must, of necessity, move on and leave in its wake a mass of miserable people totally unaccustomed to using their own God-given talents and resources to exist.

There is the moral in this story of the sea gulls of St. Augustine. It's a pungent moral and one that every voting American should well consider. Nature has a way of exacting a heavy toll from those who look upon her gifts as unnecessary. As a nation, we here in America have been singularly blessed with a tremendous capacity for using our skills and our ingenuities to ever improve our way of living. But we have earned our keep by wresting it out of the ground, the sea and the air, through the exercise of our own talents.

We will keep those talents only by continuing to use them. The minute we cast them aside as no longer necessary, we will forfeit them as surely as the sea gulls of St. Augustine forfeited their talent to provide themselves with food.

Let's not be that foolish. Let's remember what happened to the sea gulls whenever we are tempted by the Washington "shrimpers" to leave our own board and dine at the government scrap table of false security.

Old Dame Nature is a wise though sometimes cruel teacher. She might have used the sea gulls of St. Augustine as a red flag of warning to the American people. Let's heed it while we still have time.—From the *Fort Lauderdale Daily News* (Florida), April 12.

AFL UNION OPPOSES HEALTH BILL

The Chief of the AFL Carpenters' Union declared he and a majority of his union's 700,000 members stand with doctors in opposing compulsory health insurance.

William L. Hutcheson, general president of the United Brotherhood of Carpenters and Joiners of America, and a vice president of the American Federation of Labor, told this to the American Medical Association's house of delegates.

* * *

Ill and unable to appear in person, his speech was read by an assistant.

(Continued on Page 30)

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AF OF L UNION OPPOSES HEALTH BILL

(Continued from Page 28)

At the union's September convention in Cincinnati, "300 delegates, representing better than 54 per cent of the total membership, voted down a resolution to support the national health program," Hutcheson said.

"This probably does not jibe with the feelings of a good deal of the rest of the labor movement."

"But it does reflect my sentiments and the sentiments of our recent convention."—*Detroit Free Press*, Dec. 8, 1950.

**ASKS DOCTORS' AID IN
FIGHTING COMMUNISM**

In a guest editorial, appearing in the November 25, 1950, issue of the *Journal of the American Medical Association*, John Edgar Hoover, director of the Federal Bureau of Investigation, asks "the physicians of America, like other citizens," to help protect the nation's internal security.

He asks doctors to report immediately to the FBI "any information of this nature which might come into their possession."

"The FBI," he said, "is not interested in opinions or ideas, idle rumor or malicious gossip—only in facts. Like you, as physicians, we want to know the unvarnished facts of the case. To fulfill our responsibilities, we seek to determine all available facts and then forward them without comment or evaluation to the Department of Justice."

"Americans can defeat the Communist challenge—and in a democratic manner. Witch hunts, hysteria and viligante actions are repugnant to the democratic tradition. They weaken the majesty of law and provide the Communist agitators with additional talking points. If each person in America would stop and think, learn to 'peel off' the 'outer skin' of Communism, often deceptively painted with glittering promises and glorious utopias, and recognize Communism for what it is—terror and injustice—then America would have no fear."

"The keys of victory must be alertness, eternal vigilance and the maintenance of calmness. A healthy nation, like a healthy body, must receive the unstinting cooperation of all its component parts; if one part fails to carry its share the whole organism is weakened. America, at this critical hour, must remain strong and healthy. This is the task of each and every person."

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Medical Profession since 1903. MJ1-51

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MODERNIZE YOUR LABORATORY...

Make your laboratory as efficient as your examining room. Equip it with a modern Hamilton laboratory bench designed for compactness, yet with space and accommodations for everything you need. Save valuable time and precious energy by concentrating all your laboratory equipment and materials in this one convenient unit.

The working surface is dark gray unbreakable resisto $13\frac{3}{8}$ "x65". It has seven large, wood-steel drawers ranging from $3\frac{1}{8}$ " to $7\frac{3}{4}$ " deep. The big cupboard provides ample storage space for bulky boxes and bottles. Chrome plated gas, air, electric and water services are located above the working surface. Above the cupboard unit is an acid resisting porcelain enameled sink. See this "One-Piece" laboratory at—Randolph's.

"For Finer Equipment"

Randolph Surgical

SUPPLY COMPANY

PHYSICIANS AND HOSPITAL SUPPLIES

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Blue Shield News

MICHIGAN DOCTORS FAVOR NEW \$5,000 BLUE SHIELD CONTRACT

The letters sent by Michigan Medical Service to all the doctors in Michigan, on November 7 and 10, announcing the new \$5,000 family income ceiling contract, brought more than 600 unsolicited responses before December 1, including fifty new participating agreements and seven cancellations.

The Michigan Medical Service field force, which has been interviewing doctors throughout the State on the question of the new contract, has reported overwhelmingly favorable sentiment.

As a result of the letters and interviews, Michigan Medical Service has concluded that the medical profession is clearly in favor of the new contract. Final details are being ironed out preparatory to offering the \$5,000 contract to the public.

NATIONAL BLUE SHIELD SERVICE, INC., ORGANIZED

An important development on the National Blue Shield front is the establishment of National Blue Shield Service, Inc., on December 3. It has been incorporated in Ohio and chartered as an Ohio disability insurance company.

National Blue Shield Service, Inc., will be operated in conjunction with Blue Shield Plans to develop (1) supplemental coverage to that provided by the local Blue Shield Plans and (2) coverage for the areas that have no Blue Shield Plans, in cases where national accounts are involved that require uniform coverage on a nationwide basis.

National Blue Shield Service, Inc., will in no way infringe upon the autonomy of each Plan, or take over any of their administrative functions, but will serve only to provide the inter-plan mechanics necessary to service the increasing number of accounts that require national coverage under a contract providing uniform rates and benefits.

Under the Articles of Incorporation, fifteen directors are specified. At least eight of the directors must be doctors of medicine, with the 41 contributing Plans entitled to nominate ten of the fifteen directors.

At its meeting in Cleveland on December 3 and 4, the Blue Shield Commission, in order to expedite the organization of National Blue Shield Service, Inc., unanimously decided to recommend a list of fifteen persons to be elected as the first Board of Directors for the limited period pending the full organization of the national corporation.

The list proposed is as follows: Drs. L. K. Sycamore, Frederic E. Elliot, Carlton E. Wertz, J. A. Daugherty, A. R. Lutz, O. B. Owens, L. Howard Schriver, R. L. Novy, F. L. Feierabend, A. J. Offerman and H. L. Gardner.

Also, Dr. Paul R. Hawley, Chicago, Charles H. Coghlan, Executive Vice President of Ohio Medical Indemnity, Jay C. Ketchum, Executive Vice President of

Michigan Medical Service, and W. M. Bowman, Executive Director of California Physicians' Service.

It is hoped that the first election on a permanent basis and the first annual meeting of shareholders can be held in Biloxi, Mississippi, at the time of the 1951 annual meeting of the Blue Shield Medical Care Plans.

DRAFT FAILS TO MEET NEED FOR MEDICS

Selective Service failed to produce on schedule 300 physicians the Army had requested to relieve a dire shortage.

A draft spokesman said he did not know when the quota could be filled.

The Surgeon General's office reported that the shortage of physicians and dentists had put the Army's medical service "under terrific strain," with many professional men working 24 to 30 hours straight.

It appealed to physicians to volunteer immediately.

A draft spokesman said the process of examining and classifying the medical men is proceeding, but he did not know when the first of them would be inducted.

The Surgeon General's Office said it is short 450 physicians now, even though 229 had volunteered up to the end of last week.

Besides the 300 physicians requested for Wednesday, the Army has asked draft officials to supply 300 physicians, 300 dentists and 50 veterinarians by Dec. 15.

Selective Service has been asked to produce a total of 1,522 physicians, dentists and veterinarians by January 15.—*Detroit Free Press*, Nov. 16, 1950.

MEDICAL CARE FOLLOWING A FUTURE ATOMIC BOMBING

It is unrealistic to plan for less than 40,000 to 50,000 severely burned persons in a single (wartime) atomic explosion. Testimony before the Joint Committee (on Atomic Energy) has suggested that merely furnishing the initial first aid and treatment for a disaster such as Hiroshima would demand nearly 200 railroad box cars for transportation! Or one can portray the dimensions of the problem differently. It has been estimated that ideal care of a severely burned patient would call for forty-two tanks of oxygen, three nurses, 2.7 miles of gauze, thirty-six pints of plasma, forty pints of whole blood, and 100 pints of other fluids. Or one can set forth the problem's magnitude yet differently. The Joint Committee has been told that several million pints of blood might be needed during the first few weeks after an attack on our civilian population.

If, within a brief span of time bombs numbered by scores were detonated in American cities, the hard fact is that completely adequate medical treatment would be impossible.

The only complete defense against atomic weapons would come from abolishing them through effective international control.

(However), the Joint Committee hearings have revealed that in Washington, in the States, and in our local communities a great deal of sensible civil defense planning is now under way, and that continuing progress can be expected.

From an address by Congressman Carl T. Durham, Vice-Chairman of the Congressional Joint Committee on Atomic Energy, at the 1950 Convention of the American Pharmaceutical Association, Atlantic City, New Jersey, May 4, 1950.

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of the Michigan State Medical Society

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VOLUME 50

JANUARY, 1951

NUMBER 1

Observations on the Intravenous Use of Pitocin in Obstetrics

By Lawrence F. Burnett, M.D.

Newark, New Jersey

and

S. A. Cosgrove, M.D., F.A.C.S.

Jersey City, New Jersey

FROM TIME immemorial those responsible for the care of women in pregnancy and parturition have been troubled by the failure of the uterus to contract properly and efficiently when it should, or when they want it to. Hence, such attendants have always been intrigued and interested in substances which have the power of augmenting uterine contractions. The most dramatic situation in which such failure of proper contractility of the uterus endangers the mother's life from hemorrhage is following the completion of parturition due to atony of the uterus. The next most common situation in which the doctor naturally desires the aid of an oxytocic agent is where labor fails, due at least in part to failure of efficiency of uterine contractions. The third broad situation requiring such an agent is where it is specifically desired to initiate artificially contractions of the uterus looking toward the early expulsion of the baby. Such necessity for induction of labor attends various conditions in which it is feared that prolongation of the pregnancy may be against the interest of the mother or the child.

To date two groups of effective agents for the stimulation of uterine contractions exist. They

From the Margaret Hague Maternity Hospital, Jersey City, New Jersey.

Presented at the Eighty-fifth Annual Session of the Michigan State Medical Society, Detroit, Michigan, September 20, 1950.

JANUARY, 1951

are ergot and its synthetic derivatives, and several products of the posterior pituitary gland of animals.

It is probable that ergot has been known to possess this property for many centuries. Its first introduction into formal obstetric therapeutics, however, would appear to be a letter from Dr. John Stearns of Saratoga County, New York, in 1807. He called it "pulvis parturiens." He appears to have used it mostly to stimulate sluggish labor. Even in his original communication, however, he warned against its use except where conditions were favorable for natural delivery. Following this introduction the drug became very widely used and was recognized as one of the important items in the obstetric armamentarium. Curtis some years ago named it as one of the very few contributions to obstetric practice which up to that time had emanated from the United States. Very naturally its wide use was accompanied by a great lack of discrimination in that use. Practitioners even up to fifty years ago appear to have used it rather indiscriminately in all stages of labor. Inevitably such use led to frequent tragedy, so that by the early years of this century rigid rules for the restriction of its use were embodied in medical teaching, which was summed up in the dictum that it should never be used before the completion of the third stage of labor.

In 1906 Dale published an observation that pituitary extract would cause contraction of uterine musculature. It was apparently not taken advantage of, however, in a therapeutic way until Bell published his results of three years' observation in 1909. He gave recognition to Hendry for priority in its actual use. About 1913 it became available commercially and was at once widely used. The senior of us well recollects his first use of pituitary extract in that year. The patient was a grand multipara whose baby's head hung in mid-pelvis with the cervix fairly well dilated and

the woman's pains petering out. He administered a full ampule of pituitary extract and hardly had time to take position to receive the baby before it was catapulted out of the vulva at him. Needless to say, both doctor and patient were decidedly impressed with the new "wonder drug."

From this time on men forgot all the lessons that a century's experience with ergot had taught them. Pituitrin, as ergot had been before it, was employed in a most indiscriminating fashion, and in what we would today consider tremendous doses. For about a decade nearly all the articles both in this country and abroad were laudatory of the new drug and, strangely enough to us of today, insisted on its safety. But only shortly after his own first use of it one of us witnessed a case in which the attendant, believing that his primiparous patient had the head fairly well into the pelvis and the cervix fully dilated, administered a full ml. of pituitrin. She promptly ruptured her uterus and died before surgical intervention could be undertaken. Postmortem examination showed that the supposed full dilatation of the cervix was not actually more than 2 cm. Experiences such as this came to be encountered so frequently that once more physicians scrutinized the use of pituitrin from the standpoint of its dangers, once more recognized the great danger inherent in its use under improper conditions, and once more arrived at the dictum that pituitrin should never be used before the termination of the third stage of labor.

But while sounder ideas were thus applied to the use of both ergot and pituitary extract and their modern refinements in form, the desirability of the induction of labor prior to its natural onset remained a very present problem in everyone's practice. Formerly the conditions for which induction of labor was thought to be desirable formed a large list, including the following:

Contracted pelvis	Psychoses
Toxemias of pregnancy	Epilepsy
Antepartum hemorrhage	Neuritis
Accidental hemorrhage	Tetany
Heart disease	Otosclerosis
Tuberculosis	Polyhydramnios
Diabetes	Hydatidiform mole
Hyperthyroidism	Habitual death of fetus
Chorea	Postmaturity
Pernicious anemia	Intrapartum death of fetus

Many of these causes are obsolescent in reference to modern practice. But the necessity of

terminating pregnancy in serious toxemic states is increasingly recognized. Moreover, some practitioners induce labor electively for their own convenience and that of their patients. This indication we by no means endorse.

For almost four centuries induction of labor has been practiced by a great variety of means, many of which have been abandoned, and none of which have been uniformly successful.

Men have therefore persisted in the search for a reliable drug to employ as part of, or in substitution for, other methods, and it has been repeatedly conceived that pituitrin might be a nearly ideal agent for this purpose if it could be so used as to eliminate its danger. Hofbauer in 1912 and Watson in 1913 published reports of successful induction of labor with pituitary extract. Through the years the safety of the inclusion of pituitrin in various techniques of induction was sought by the use of fractional dosages. Thus Watson in 1922 published a combined technique for induction including doses of 0.5 ml. of pituitary extract, repeated if necessary to a total of six injections. He did not escape considerable criticism for the inclusion of pituitary extract in this regime, but it nevertheless became widely accepted for a while. In 1927 Hofbauer suggested administering pituitary extract on small pledglets of cotton inserted into the nostrils, from which he assumed the absorption would be slow, thus minimizing the danger from the start. His purpose was to immediately terminate any excessive effect of the pituitary extract by prompt removal of the pledglets of cotton. This method, however, did not obtain wide acceptance, as its results did not prove especially satisfactory.

Still men's imaginations lingered on pituitrin or pitocin, the nearly pure oxytocic fraction of pituitary extract, and throughout the years various authors made reports of its use, claiming a satisfactory degree of success. In 1947 Eastman tentatively reported a fairly large series of cases in which pituitrin was used for the induction of labor. Shortly after Eastman's report, Hellman, at that time in Eastman's clinic, suggested the constant intravenous administration of very dilute solutions of pitocin with the idea that by this means the effect could be very critically appreciated. The administration was instantly stopped in event of any degree of undesirable effect of the drug on the uterus. Since that time Stone, Hellman, Harris, Reynolds and others have reported

the use of pitocin for the induction of labor in this fashion.

The present report is of a series of 457 cases in which Hellman's suggestion of intravenous administration of very dilute solutions of pitocin have been used for the induction of labor, for the augmentation of deficient uterine contractions during the second stage of labor, for the control of immediate and remote postpartum bleeding, and for the expulsion of the retained placenta in certain cases of abortion. The series in some categories is too small upon which to base conclusions.

In reporting any method of induction as successful, it has seemed to us that the induction must be successful on the first attempt. In Matthieu's report in 1927 he stated that by the method of induction of labor therein recommended, 71 per cent were successful at the first trial, whereas 96.7 per cent were successful on repeated trials. To claim success of any method when it has to be used repeatedly would seem to us fallacious. If one gave hypodermic injections of sterile water for the induction of labor and continued to repeat it frequently enough, eventually labor would, of course, occur. But one would hardly ascribe its onset to the sterile water. So that in our own series we have defined successful results as those in which the initial use of the method succeeded.

Our whole series in which pitocin was administered in very dilute solution by the intravenous method was 457. Of these, 321 were for the induction of labor. Of this number 247 (77 per cent) were successful as herein defined—that in spite of the fact that in the majority of cases the cervix at the beginning of induction was less than 4 cm. dilated. In the rest of this group, seventeen cases (5.3 per cent) responded to repetitions of the induction but are classed as failures according to the strict definition of success which we have adopted.

A much smaller number were subjected to the administration of pitocin in this fashion for augmentation of pains in labor. These cases were of two groups. First there are those cases in which the advancement already attained promised early successful conclusion of the labor by a moderate augmentation of the pains existing when it was employed. In several of this group we are convinced that the spontaneous outcome of labor which was effected would not have occurred except by the use of the pitocin. Second there are those cases characterized by very inadequate

uterine contractions in the presence of borderline disproportion in which we did not desire to resort to radical surgery until that need became evident in the presence of more adequate contractions than the patient had exhibited up until that time. Here, if labor did not progress toward successful outcome in the presence of reasonably satisfactory labor induced by the pitocin, the indication for radical surgical intervention became clearcut. Of the first of these two groups there were eighty-six cases, forty-four of which delivered spontaneously, twenty-eight necessitating only the use of simple forceps extraction for eventual delivery. Of the second group fourteen cases did come to section, whereas in four cases we felt that necessity for recourse to section had been obviated by the pitocin.

Fifty cases were treated for immediate or delayed hemorrhage due to uterine atony after the termination of the third stage of labor. In all but one of these the method appeared to be effective, although we have no basis for believing that it was more effective than the administration of pitocin by other means.

Only a very few cases have been treated for postpartum or postabortional retention of the placenta. The method has been successful in these cases. But again we have no strong conviction that the administration of pitocin by other methods would have been less effective. We feel, however, that the maintained minimal effect of pitocin which the method represents is gentler and perhaps might be in some degree less dangerous than the administration of larger doses by other methods. Besides, the by no means rare occurrence of successful induction by pitocin intravenous drip after the failure of pitocin series by hypodermic may indicate the actually greater efficiency of the intravenous method.

Our technique of induction is to give 2 ounces of castor oil, followed in one hour by two warm soap-suds enemata; then we immediately start the intravenous administration of 0.5 ml. of pitocin (5 International units) in 500 milliliters of 10 per cent glucose in distilled water. The tube from the flask of this solution is connected to the intravenous tubing by a Y-tube, the other limb of which is connected to a flask of 10 per cent glucose in distilled water. Stop-cocks are placed between either flask and the Y-tube. In this manner either the pitocin solution or the glucose solution may be interrupted and the other allowed to run at

will, depending upon the patient's reaction to the pitocin solution.

Parke, Davis pitocin is supplied in 0.5 ml. ampules containing 5 International units of pitocin. The dose indicated on the carton is 5 to 16 minims repeated at twenty- to thirty-minute intervals.

This would seem to imply that amounts up to 16 minims are eliminated in thirty minutes.

Our own practice for induction is to use doses of 0.5 to 2 minims at thirty-minute intervals.

This means that immediately on absorption of 0.5 minim hypodermically, say within one minute of the injection, there would be $\frac{1}{3}$ of a unit in the circulation.

In the intravenous use of highly dilute solutions we use 5 units in 7500 minims or $\frac{1}{1500}$ units per minim. If such solution is run at 60 minims per minute, there is introduced into the circulation in one minute $\frac{1}{25}$ of a unit, or about one-eighth of even the smallest hypodermic dose. At the rate of elimination indicated above, there can be no accumulation at this rate of dosage.

We have not included artificial rupture of the membranes as a primary part of the inductive procedure. Rey craft, to whom we are indebted for certain of the data in this paper, and who has recently reported a large series of cases induced wholly by the artificial rupture of the membranes, has experienced an 18 per cent latent period in primigravidas of six hours or more up to twenty-seven hours, and in multigravidas a 10 per cent latent period of six hours or more up to twenty-one hours. We therefore prefer to reserve artificial rupture of the membranes until labor is well established and considerable progress in the dilatation of the cervix and the accommodation of the presenting part to the inlet has been attained.

No accidents to mothers have resulted from our use of this method and no cases of maternal morbidity dependent upon it have been observed. Only one baby was lost whose death can in any fairness be attributed to the method. The gross fetal loss was:

Thirteen cases of antepartum death *in utero*, including two missed abortions, one abruption, one strangulation by cord, five associated with severe maternal toxemia, one with maternal diabetes, and three for which no cause could be found;

Seven intrapartum deaths, including one anencephalus, one occurring before pitocin, one injury in breech extraction, two associated with abrup-

tion, one with placenta previa, and one unknown. There is a possibility that one of the abruptions might have been due to the pitocin.

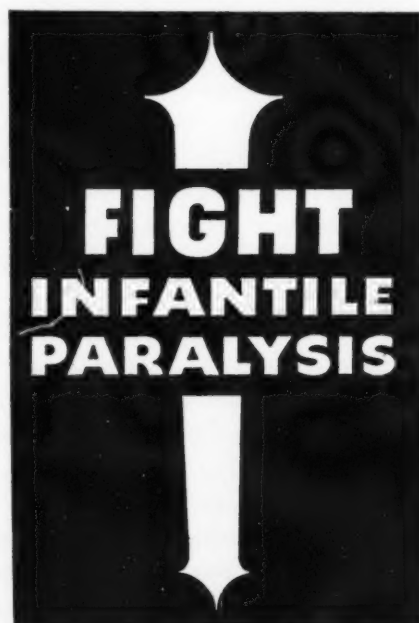
Seven neonatal deaths, including one anencephalus, one hydrocephalus, one hydrops fetalis, one from intracranial trauma, one prolapsed cord, and two from atelectasis in premature infants of toxemic mothers.

The total fetal loss therefore is twenty-seven (5.91 per cent).

In summary, we present 457 cases of the intravenous use of very dilute solutions of pitocin and have found it to be so far entirely devoid of maternal, and of minimal fetal, danger. Our percentage of success in the primary use of this method in the induction of labor compares favorably with the reports of other methods of induction. It is a preliminary report only. A subsequent one will add further cases to the series, and embrace a much more detailed analysis of the data concerning all.

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MARCH OF DIMES



JANUARY 15-31

Overcoming Hemorrhagic Puerperal Mortality

By S. A. Cosgrove, M.D., F.A.C.S.
Jersey City, New Jersey

THROUGHOUT medical history the loss of women's lives in childbirth has been caused by three principal factors, namely, sepsis, toxemia and hemorrhage. Until less than a century ago sepsis caused more deaths than either of the other factors named. A generation ago the three ran more or less together with sepsis and toxemia predominating.

In the last quarter century, and particularly within the last decade, the general mortality rates from all causes throughout the country have been materially less. For instance, in Michigan there were 9.3 puerperal deaths per thousand in 1920, 2.19 in 1940, 1.7 in 1947. Septic deaths have almost disappeared due to improvements in techniques in respect to antisepsis, asepsis, and the elimination of unnecessary and injudicious surgery; the influence of the introduction of sulfa drugs and of numerous antibiotics has also been a tremendous contribution to the control of septic complications of parturition. Sepsis is now a rare cause of death where cases are properly hospitalized, and where the hospitals have the opportunity of controlling them before they are essentially moribund.

Toxemia also has become theoretically nonexistent, on the assumption that if prenatal observation and control is adequate and universal, no patient need approach danger of death from toxemia. This almost complete disappearance of toxemic deaths is literally a fact in those great clinics which are able to control all their patients from a period early in pregnancy. So much is this true that some clinics complain that they do not see enough toxemias, especially the fulminant life-threatening types, to furnish material for undergraduate teaching.

Unfortunately, the education of the laity and the profession as to the need for, and proper quality of, prenatal care has not attained universally the degree of perfection represented in

the clinics alluded to. Therefore, those clinics which have the responsibility of admitting patients whom they have not had under their own control since early pregnancy, do continue to encounter many cases of severe toxemia and a few even of eclampsia. But the elimination of meddlesome obstetric surgery and the development of physiologic regimes of treatment have caused a marked improvement in the mortality even of this group of cases. The result, therefore, has been that both from sepsis and toxemia, maternal mortality has kept fair pace with the improvement in general mortality records. These factors have actually been the backbone of the whole mortality decrease.

The improvement in mortality from hemorrhage, however, has not quite kept pace with that of sepsis and toxemia. It has very definitely improved, and this improvement is increasingly shown during the past few years. Ten years ago the death rate from hemorrhage in excellent clinics was about 1 in 1,400 cases; today, in the whole state of New Jersey the rate is about 1 in 4,500.

There are reasons why successful control of the mortality from hemorrhage does not lend itself to the several factors which have so aided in controlling sepsis and toxemia. Certain hemorrhages are not preventable and when they occur, do so unexpectedly and rapidly develop most urgent and dangerous implications. But certain classes of hemorrhage are in large degree preventable. Whether preventable or not, there has been vast improvement in the resources for meeting the danger which all of them represent. So far is this true that I am able to report to you the almost entire elimination of hemorrhagic death in many thousands of cases. Mr. John Stallworthy, of the Oxford Area hospitals in England, recently reported no hemorrhagic death since 1940 and definitely suggests the maintenance of this record as an attainable objective. In our own clinic there has been only one hemorrhagic death since May, 1945, representing 46,000 deliveries. If this can be done in reference to such large groups of cases, the possibility of extending it to other large groups, and to communities and states, is reasonably possible. This, like all ideal attainments, is achieved only by co-ordination of effort along many lines, at the expense of thought, planning, co-operation of many individuals, and actual monetary expense.

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Every pregnant woman bleeds at some time before the pregnancy is completed, no matter what the form of pregnancy may be and no matter what the form of its termination. In normal pregnancy such bleeding is entirely physiologic and is clinically unimportant provided it is restricted within rather narrow quantitative limits. Thus, the very slight bleeding which Hertig has shown sometimes occurs physiologically in the very early weeks of pregnancy, associated with the nidation of the ovum; the "show" which frequently signals the beginning of labor, representing some escape of blood from the dilating turgid cervix; the bleeding which physiologically attends the detachment of the placenta during the third stage of labor; and the moderate lochia which physiologically characterizes the immediate puerperal period—are all physiologic.

Bleeding, however, which attends pathological pregnancy, as ectopic gestation, abortion, premature separation of the placenta, placenta previa, is abnormal by reason of the fact that it does attend abnormal behavior of the pregnancy. Besides, all of the other forms of bleeding which I have characterized as physiological may become pathological by reason of quantity of the bleeding attending physiological phenomena listed. The very slight early bleeding attending the nidation of the ovum may become excessive and manifest itself as abortion. Abortion itself may present dangerously excessive hemorrhage on occasion. The bleeding attending the beginning of the dilatation of the cervix in rare precipitous labors may progress to actual extensive laceration of the cervix with consequent dangerous bleeding. The separation of the placenta may be attended by so large an amount of bleeding as to jeopardize the patient. The bleeding of the fourth stage of labor, the period immediately following the third stage, frequently manifests itself as postpartum hemorrhage. This may be due to many causes but by strict definition is limited to that caused by inertia of the uterus. Therefore the obstetrician should recognize that every case of parturition represents potentialities of dangerous hemorrhage. He must try to anticipate that possibility whenever he can. He must invariably be prepared to actively manage his cases of abnormal bleeding so that lethal outcome does not occur. In other words, he must have a program for efficiently controlling hemorrhage and its effects when it occurs, with the utmost promptitude.

Such a program will be of two phases. I have indicated that some hemorrhages are unavoidable and unpredictable, some of them very definitely avoidable. The scheme then upon which the obstetrician relies must seek to avoid as many hemorrhagic situations as possible. This will involve his whole philosophy of practice and will concern itself with all the stages of labor.

During the first stage of labor all factors concerning the patient's general condition and her behavior in labor must be scrutinized to appreciate any imminent potentiality of hemorrhagic danger. For instance, does she show some evidence of toxemia? If so, the possibility of premature separation on the basis of the toxemia should be foreseen and means taken to provide for its prompt treatment should it occur. Does she show dystocia or possibilities thereof? Then the danger from hemorrhage from laceration caused by operative vaginal delivery, or excessive hemorrhage attending cesarean section, must be foreseen and provided against in advance. Close observation to detect any evidence of actually occurring hemorrhage either evident in obvious vaginal bleeding or the constitutional effects of hemorrhage, should be maintained. This alertness to anticipate potentialities by provision of means of meeting them will pay big dividends in the occasional emergencies which will arise.

During the second stage management must have for its primary objective avoidance of premature or unnecessary surgical interference. I would like to stress this in especial reference to the time factor. No phenomenon of labor should be measured by the clock. There is no reasonable compulsion for limiting the time duration of any of the phenomena of labor. There can be no fixed proper length of the so-called second stage of labor. There is no compulsion to terminate labor within any particular time following the full dilatation and retraction of the cervix, because the dilatation of the cervix has no necessary relation to the progress of the presenting part itself through the parturient canal. The cervix will often be fully dilated and retracted before the head is completely engaged and obstruction to its complete passage of the inlet has been eliminated. Hence, in many cases, the obstetrician should permit the spontaneous evolution of complete accommodation of the presenting to the inlet and its descent to the outlet without interference. This is almost invariably salutary, no matter what

the actual time consumed in accomplishing it may be. Such time is helpful alike to the obstetrician, his patient, and her baby. It will frequently spell the difference, if surgical interference shall eventually be necessary, between a relatively difficult instrumental delivery with very definite jeopardy to the baby, and a facile delivery free of such jeopardy.

It should be unnecessary, but unfortunately is not, to emphasize over and over that instrumental or manual operative delivery should be deft, gentle, and very deliberate. There are very few actual indications for haste in vaginal procedures for delivery. Even in the presence of fetal distress, which seemingly indicates the need for such haste, haste itself will very much more seriously threaten the slender margin of survival which such a distressed fetus presents, than will the extra time necessary in proceeding with the utmost gentleness and deliberation.

The management of the third stage of labor gives opportunity for very important prophylaxis against pathological hemorrhage. So much is this true, that it more importantly devolves upon the responsible attendant to himself carry out, or at least most closely supervise, the conduct of the placental stage of the delivery than the fetal stage thereof. There will be almost as many ideas as to how the third stage should be properly managed as there are thoughtful men actually carrying out that management. In individual experience over any great period conviction may vary from time to time in regard to that management. Whatever management any particular individual believes is best at the time he employs it, the principle is transcendently important that the responsible accoucheur should give it his definite and undeviating attention.

My own management of the third stage for several years has been to give intravenously 1/320 gr. ergotrate at the birth of the head; the torso is delivered very slowly, generally by spontaneous expulsion rather than by artificial traction. I think that this deliberation is valuable; it is a close simulation of physiologic conditions; the pressure on the torso purges the baby's respiratory passages of secretion and aspirated liquid; the mild anoxia stimulates respiratory effort; the cleared air passages and spontaneous respiration prevent dangerous anoxia.

As the torso is fully delivered, the fundus of the womb is immediately grasped by the operator

or a *trained* assistant, but not manipulated; the placenta sometimes is promptly expressed spontaneously; if it is not, moderate squeezing pressure is made on the fundus at about the time that necessary attention to the baby is complete, and the baby disposed of; if the placenta does not deliver then, the patient is redraped for episiotomy repair and again moderate expulsive pressure is employed; if occasional repetition of such effort over a period not in excess of ten to fifteen minutes does not succeed, the placenta is manually extracted.

This management is applied only in cephalic deliveries; in breech delivery, the oxytocic is withheld until after the placenta is born. The duration of the third stage is definitely shortened; the amount of bleeding attending it is significantly reduced; occasional necessity for manual extraction is not attended with additional immediate or late hemorrhage, nor by maternal morbidity; if necessary at all, it is better employed early than later. My observation has been that the failure of the placenta to deliver is not often due to *incarceration* thereof, but almost always to its *incomplete separation*. While it is true that some of these cases might completely separate in a longer time, this delay would be at the expense of significant additional blood loss.

After the placenta and membranes are delivered, the uterus is lifted out of the pelvis by the fingers of one hand introduced above the symphysis, thus fixing the lower pole thereof, while the other hand continues to control the fundus. The most important detail of this or any other scheme of management of the third stage is the exclusive and continuous attention of one individual to the behavior and control of the uterus throughout, and following, this stage. Even if the accoucheur is so unfortunate as to have to work alone, it is necessary for him to concentrate his attention primarily on the placental stage of the labor.

Should there be bleeding following the third stage, the first necessity is to ascertain its source. Make sure, by careful tactile and visual exploration, that it is not coming from lacerations of the vagina, cervix or uterine body. If it is, surgical repair appropriate to the location and nature of such damage is carried out. If exploration of the uterine cavity shows retention of placental remnants, they should be carefully removed. Only when every other source of bleeding has been

carefully ruled out, may the cause of postpartum hemorrhage be assigned to uterine inertia. If this conclusion is accepted, oxytocics should be freely exhibited and firm bimanual control maintained by one hand in the vagina grasping the cervix, the other the fundus through the abdominal wall, for *as long as may be necessary*. Do not waste time and blood, and delude yourself by packing the uterus. Any bleeding which might conceivably respond to this measure will more surely and safely do so by the maintained bimanual control described. Clamping of the cervical parametrium through the vaginal fornices is doubtless occasionally effective, but is not devoid of danger. Strong instrumental traction on the cervix itself is sometimes just as effective.

A few cases, by reason of myometrial degeneration or undetected rupture of the uterus, demand extirpation of that organ. Decision as to such necessity should not be too long delayed if it is to succeed.

Time will not permit detailed discussion of the management of such abnormal phases of pregnancy and parturition as ectopic gestation, placenta previa, and premature separation of the placenta. In all, early recognition is of prime importance and gives opportunity for desirable individualization of management. Their importance depends on the extent of hemorrhage attending them. The importance of combatting the effects of such hemorrhage is paramount.

In all of the situations discussed, the outcome to the mother and often the baby depends on actively fighting the effects of hemorrhage. The first requirement is replacement of lost blood. Only whole blood can do this. Substitute liquids may be of some temporary value in restoring deficient volume of liquid in the circulation but only blood can replace the loss of the essential oxygen-bearing red cells.

To make prompt replacement of blood at all times quickly available, previous organization is just as essential as the provision by a municipality of an organized fire department in the control of conflagration.

This organization must start with the doctor and in the doctor's office. If the doctor has no resources of help, he must train himself to type and cross-match bloods, and to give transfusions. As soon as each prenatal patient is first seen, her blood group and Rh factor characteristics should

be ascertained and recorded, and the record be furnished to the patient and to the hospital.

The hospital should maintain a blood bank, and that bank should constantly have on hand a certain quantity of processed blood, available in extreme emergency when time does not permit cross-matching. Even well-equipped and maintained blood banks should, if possible, have reciprocal arrangements with other blood banks, or with reliable donor agencies, to handle demands for blood in excess of their own current resources.

If the hospital is not able to maintain such a blood bank, arrangements may be made by it for prompt call on a list of previously typed donors.

Either of these arrangements may be organized on a community level either by the Red Cross or other volunteer agencies. This has been well done in many places. There has been discussion and experimentation in providing blood banks on state levels. The more remote sources of blood are, however, the less they can contribute to the very acute emergencies which obstetric practice represents.

In the hospital supplies of solutions of sugar in water or saline, and of plasma, with apparatus for their instant administration, should be maintained.

Personnel capable of accurately doing laboratory procedures necessary for safe transfusion, and to administer replacement liquids, should be promptly available at all hours.

The hospital must accept the responsibility for actual cash outlay for blood from its own resources if necessary, and someone should always be on duty with authority to implement that responsibility.

All patients should be promptly crossmatched on admission against available blood, if there is history of prior bleeding in parturition, if there is history or evidence of blood dyscrasia or severe anemia, if there is any evidence of bleeding on admission, if there is history or evidence of dystocia or any other potential basis for surgical interference.

The same procedure will be promptly carried out if any of these indications develop after admission or if wholly unexpected emergency arises.

If it appears probable or certain that transfusion is indicated, it should be promptly started, and the blood bank alerted for further supplies of

(Continued on Page 53)

Effect of Pregnancy on the Urinary Tract

By George C. Prather, M.D., F.A.C.S.
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SEVERAL BOOKS as well as many scientific papers have adequately recorded the known facts concerning the influence of pregnancy on the urinary tract and the more common urological diseases associated therewith. They illustrate the fact that if one is familiar with physiological as well as pathological changes in the urinary tract during pregnancy, medical counsel will be of greater value to the patient. The purpose of this paper is to state the present concepts about the subject in brief form.

Since the earliest recorded observations by the anatomist Morgagni, in 1761, describing dilatation of the renal pelvis and upper ureters during pregnancy, and the more complete description by the urologist Rayer, in 1839, there has been study and speculation as to the cause as well as the effect of the physiological hydronephrosis.

In order to illustrate this change easily by means of x-rays and to become oriented in the pyelographic world, let us say that Figure 1 represents a normal intravenous pyelogram in a nonpregnant female. Figures 2, 3 and 4 are intravenous pyelograms during normal pregnancies and demonstrate the degrees of hydronephrosis and hydroureter which are considered normal.

The pyelographic change begins about the fourth month and reaches a maximum state during the seventh, eighth or ninth month. Primiparas, in general, show a greater degree of hydronephrosis than multiparas if there has been no obstructive disease in the urinary tract prior to pregnancy.

Autopsy study by others has found the right upper urinary tract dilated in 85 per cent and the left upper urinary tract dilated in 72 per cent of primipara. X-ray studies by others and by Crabtree and Prather at the Boston Lying-in Hospital indicate that evidence of dilatation will be found in 85 per cent on the right and 55 per cent on the left. Thus, hydronephrosis and hydroureter (up-

per part) during normal pregnancy are well-established facts.

Several features of pyelograms in pregnancy are worthy of comment. Blunted calyces are a part



Fig. 1. Normal intravenous urogram in a nonpregnant female. Calyces are sharp, renal pelvis intermediate, and upper ureters follow normal course.

of the picture. The degree of change in the renal pelvis is determined in part by the intrarenal or extrarenal pattern of this portion of the kidney prior to pregnancy and in part by the extent of the general process of dilatation. Ureteral dilatation is confined to the segment of the ureter above the brim of the bony pelvis and, if the films are good, can be seen to terminate in a cone-shaped narrowing at that region. Widening of the lower ureter is indicative of pre-existing or current urological disease. Commonly a pronounced kink is seen in the upper ureter, not adjacent to the renal pelvis, at a point where the ovarian vessels cross obliquely. Just below this region the ureter frequently swings lateralward, carried to this position by intimate contact with parietal peritoneum as the uterus enlarges. In the normal, these distortions resolve rather remarkably within three months after delivery.

The histological picture of the upper urinary segments is not nearly so dramatic as the gross changes just mentioned. The renal cortex shows nothing unusual except increased vascularity. The renal pelvis appears thin with muscle bundles separated, a change similar to that which is evident in the ureter above the brim of the bony pelvis. Either there is not time for compensatory hypertrophy or other factors are at work which produce a hypotonic type of tissue. In the lower ureter near the bladder, hypertrophy of the muscle bundles and fibrous tissue of the peri-

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Presented at the Eighty-fifth Annual Session of the Michigan State Medical Society, September 20, 1950, at Detroit, Michigan.



Fig. 2. Intravenous urogram during pregnancy, breech position. There is unilateral dilatation of calyces, pelvis and upper ureter—not unusual in normal pregnancy.



Fig. 3. Intravenous urogram during normal pregnancy. There are minimal but definite changes in the upper ureters and a right hydronephrosis. The redundancy at the right ureteropelvic junction is not unusual.

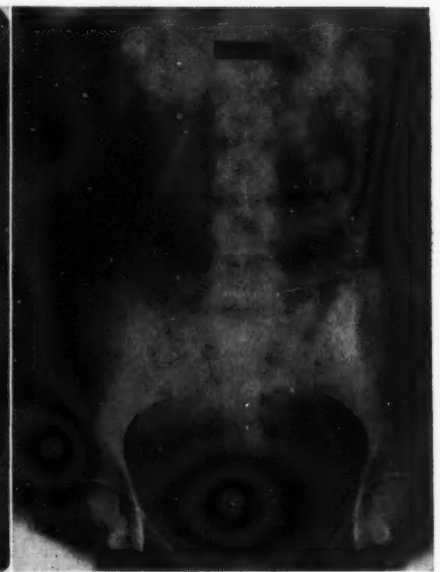


Fig. 4. Intravenous pyelogram during pregnancy. Lateral diversion of upper and mid-ureters is common and considered normal.

ureteral sheath occurs, but this finding is not believed to be the cause of the dilatation of the upper ureter.

Having described the evident physiological variations in the upper urinary tract, one would like to assign some cause to them if possible. Long before the days when certain humoral substances were known as hormones, the upper urinary tract dilatation was explained by the mechanical pressure of the enlarged uterus on the ureters at the brim of the true bony pelvis. The dextro-rotation of the uterus and the protection of the left ureter by the sigmoid sufficed to account for more frequent changes of the right ureter and kidney than the left.

However, the realization that relaxation of smooth muscle as part of the physiology of pregnancy might pertain to the upper urinary tract led to studies of ureteral tone and peristalsis. All of the pertinent contributions cannot be mentioned here, but Trout and McLane's noteworthy work demonstrated that ureteral motility is somewhat diminished in both frequency and amplitude as early as the third month of pregnancy, too early for the uterine mass to exert significant pressure on the ureters. This state of diminished ureteral tone and less frequent peristalsis reaches a maximum point in the seventh month and can be explained on a hormonal-chemical basis.

Ingenious studies by Jenkins and Van Wagenen have shown that dilatation of the upper urinary

tract in pregnant Rhesus monkeys continues after removal of the fetus by hysterotomy, thus leaving the placenta in place to be expelled at term. Further observations by them have demonstrated that, in monkeys, placental hormones continue active after death or surgical removal of the fetus. They believe that these hormones contribute to the characteristic dilatation of the upper urinary tract, although unfortunately the state of the ureter in the pregnant and non-pregnant monkey could not be influenced by the experimental use of estrogen or progesterone.

To summarize the present concept of the cause of the hydronephrosis of pregnancy, one can say that there is evidence of a placental hormone whose influence produces atonicity of the renal pelvis and upper ureter and that this change is augmented by pressure of the enlarged uterus on the ureters as they cross the brim of the bony pelvis.

Fortunately, the anatomical changes described above do not appear to have any adverse effect on renal function as measured by urea clearance, urine concentration, color dye excretion tests or blood chemistry. Therefore, when renal function is diminished, it is indicative of pre-existing disease or an acute pathological process which has affected both kidneys.

With some knowledge of the physiological changes in the upper urinary tract as they occur in pregnancy, one can proceed to the study and

treatment of urological symptoms or abnormal urinary findings as seen in obstetrical patients.

Not infrequently during pregnancy a patient describes flank pain which is severe enough to require medical aid. Assuming that there is no rise in temperature, that there is no leukocytosis and that the catheter specimen shows nothing abnormal in the centrifuged sediment, what procedures should be considered for diagnosis and for symptomatic relief?

An intravenous pyelogram will provide some clue in disclosing opaque shadows which may be calculi or calcified mesenteric glands, a soft tissue shadow suggestive of ovarian cyst, abnormal size or position of a kidney, or delayed secretion by a kidney indicating unusual obstruction. At times it is difficult to distinguish between the physiological changes already described and a truly obstructive situation giving rise to renal pain, but with the pyelographic films at hand the doctor can speak with reasonable confidence regarding the condition of the kidney on the painful side. If it is believed that the patient's pain is caused by distention of the renal pelvis, but not by a pathological process, postural drainage with the foot of the bed elevated in combination with sedatives usually suffices. Although discomfort may last for a period of days and is at times recurrent, I have never seen a patient who required prolonged treatment.

Gross hematuria is a symptom which is not uncommon during pregnancy. One immediately recalls conditions such as stone, trauma, tuberculosis, tumor, varicosities or infection as possible causes. At times all of these diseases can be ruled out and the cause remains obscure. Calculi usually cause gross hematuria less frequently during pregnancy than in the non-pregnant, perhaps because there is more room in the dilated upper urinary tract. I have seen only two cases of bladder tumor during pregnancy and no renal tumors. Tuberculosis is not uncommon in the age group with which we are concerned and merits consideration. Varicosities of the bladder base are visualized frequently by cystoscopy, but their presence does not rule out hemorrhage of renal origin. Cystitis of the hemorrhagic type with red splotches evident in the bladder mucous membrane, common in all age groups, usually produces intense bladder distress. Gross hematuria from a kidney as visualized by a bloody jet from a ureteral orifice in the presence of a normal

pyelogram leaves the urologist with an amazed expression and at a loss for authoritative words. Fortunately, in this circumstance the symptom is usually temporary and not prone to recurrence. Pyelonephritis, as well as acute nephritis, can cause gross hematuria.

We believe each case of hematuria warrants study which includes urine culture, stained urine sediment, culture or guinea pig investigation for tuberculosis, intravenous urograms and bladder cystoscopy. Retrograde study is advised if the intravenous urograms are not satisfactory. In unusual circumstances the aid of the hematologist must be sought.

Pyuria or bacteriuria are common observations during pregnancy if one takes the time to do more than the routine albumin and sugar tests on catheterized urine specimens. It is needless to repeat that a catheter specimen is the only reliable sample for microscopic examination. We might consider two general groups of patients with evidence of urinary infection in the catheterized specimen.

First, we may discuss the patient who is afebrile with no bladder symptoms and who is not aware of any abnormality. If there is no previous history of pyelitis or other renal disability, the logical procedure might well involve routine medication with one of the sulfonamide or antibiotic preparations, checking on the catheter specimen by microscopic examination during the period of medicinal treatment as well as two to four weeks after treatment is completed. If the urine becomes and remains negative, no further studies should be required. However, should the urine fail to clear or become infected again after medication has been stopped, anatomical studies by intravenous urography should be done. Further efforts to clear the urine by means of aureomycin or chloromycetin would be in order hoping to prevent a possible febrile episode later in pregnancy.

We advise routine intravenous urograms in any patient with a previous history of renal disorder and with an infected urine, even though the patient may have no symptoms during her pregnancy. In order to estimate the renal situation accurately one must have the benefit of indirect visualization of the kidneys and ureters by x-ray study.

In the second group of patients with pyuria is the woman with acute febrile pyelonephritis during pregnancy, a complication having an in-

cidence of 2 per cent in most large obstetrical hospitals. Bacterial surveys have shown that *E. coli* is the most common organism responsible for the infection, but even so, routine urine cultures are advisable in hospital practice in addition to the observations of the wet urinary sediment and the stained sediment.

Prior to the days of potent urinary antiseptic medication, the natural history of repeated attacks of pyelonephritis or continued renal infection became evident in histological studies obtained by surgical biopsy or post-mortem examination. Studies by Weiss and Parker some years ago revealed that the inflammatory process involves not only the tubules and interstitial tissue but the arterioles as well. The kidney can survive an acute attack nicely unless there is urinary obstruction, but with repeated or continued infection destruction of vital elements leads to insufficiency. Studies by Prather and Sewall revealed that patients with pyelonephritis in one pregnancy did not commonly develop toxemia in succeeding pregnancies. With these data, we as physicians have a real obligation to individuals with renal infection. We should know as much as possible about the anatomical status of the kidneys in order not to overlook a significantly obstructive lesion, and we need to employ proper medication, making sure of its effect not by statements of the patient or by improvement on the temperature chart but by frequent examinations of the catheterized specimen.

The symptoms of pyelonephritis are well known to all of you. In the pregnant patient, a chill or an abrupt rise in temperature is the most frequent initial symptom. Flank pain or tenderness is often present but not always as marked as the febrile reaction might indicate. A toxic reaction with nausea and vomiting is common. Rarely do bladder symptoms give a clue pointing to the urinary tract as the source of the fever.

The diagnosis rests of course with the presence of bacteria in the urine specimen during the first few hours of the infection, followed shortly by pyuria unless there is complete obstruction of the affected kidney.

Treatment of pyelonephritis in pregnancy requires attention to hydration—intravenous fluids when the patient is unable to take 3000 c.c. per day by mouth. Postural treatment with the foot of the bed elevated and sedatives may be required if flank pain is troublesome.

The stasis of urine, evident with the physiological hydronephrosis, creates a real proving ground for any drug that hopes to qualify as a so-called urinary antiseptic. Prior to the days of sulfanilamide no known medication would produce a sterile urine in pyelonephritis of pregnancy. With the original sulfa drug we found that 68 per cent of patients were cured, which by definition we mean obtained a sterile urine during medication and which remained sterile during the remainder of pregnancy. About 20 per cent obtained a sterile urine during medication but developed an afebrile pyuria after medication was stopped, while 12 per cent did not improve their urinary sediment during sulfanilamide therapy.

At the Boston Lying-in Hospital experience with sulfadiazine closely parallels the results with the other sulfonamides. The usual program is 1 gram four times a day for five or seven days. With the hydration program mentioned previously there has been no complication of crystalline obstruction or toxic reaction in the renal cortex causing anuria.

In coccus infections one naturally turns to penicillin, but I do not sanction the routine use of this drug in urinary infection.

Data are not available at this time to judge the efficacy of the newer antibiotics, such as, aureomycin, chloromycetin, and terramycin in a large series. Suffice to say at the moment that they appear to be at least as effective as sulfonamides, but scattered failures in sterilizing the urine of pregnant patients prevent one from assuming that all will be cured. We have employed 250 or 500 milligrams of aureomycin or chloromycetin four times a day.

The necessity for cystoscopic drainage and irrigation of the infected kidney in pregnancy has become much less frequent in recent years. It is employed at present only when lack of progress by medical treatment is evident or when calculi or other obstructions inhibit effectiveness of the oral medication.

By the same token surgical interference is limited to the case with pre-existing renal disease which has become aggravated by pregnancy, thus producing a dangerous situation for the welfare of the patient.

Interruption of pregnancy is rarely necessary today for pyelonephritis but may be advised if total renal function appears deficient.

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Pain Relief During Labor

By Norman F. Miller, M.D.

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PAIN RELIEF is today one of the more popular subjects for discussion amongst those who practice obstetrics and, perhaps, justly so. To relieve human suffering is an important part of our responsibility as physicians. Much of the discussion stems from the fact that we have no entirely satisfactory, practical, universally acceptable system for pain relief. Discussion of this subject is, therefore, desirable, since it tends to clarify understanding and iron out the numerous problems connected with the use of pain-relief methods.

It hardly seems necessary to raise the question, "Do women have pain during labor?" The answer is so obvious as to seemingly merit little comment; yet, no consideration of pain relief would be complete without some mention of this aspect of the subject. Few people are bold enough to hold that the average woman does not have pain during labor. Some individuals, however, believe that labor amongst primitive women was not associated with pain, and that labor pain is a more recent acquisition in the evolution of womankind based on our way of living and based on fear. Without intending to be facetious I believe few of us are sufficiently familiar with primitive mankind or with the actual discomforts tolerated by women during the birth process to accurately evaluate these points. However, we do know that whatever its cause—whether fear or muscle stretching—modern woman can be mighty uncomfortable during the birth process, and our every inclination is to endeavor to give surcease—relief with safety.

It has been said that a mother who gives birth to her child in pain is emotionally better off than those whose discomfort, and even consciousness, has been blocked out during travail. Statements of this sort emanating from the male sex may be taken with a grain of salt. However, some women have also expressed this view; consequently, it behooves us to give this matter careful consideration.

The effect of fear upon bodily function should be well known. The effect of fear on emotional equanimity and stability should likewise be com-

mon knowledge for medical people. Yet it sometimes appears that this influential relationship, if truly known, is either commonly overlooked or ignored in the management of obstetric patients. There is, indeed, abundant reason to indicate that for the vast majority of pregnant women modern medical care—good as it is—fails to fully or adequately utilize opportunity for minimizing fear—especially that under the surface, not talked about kind of concern—fear—felt by most women approaching term. Fear of the unknown is common amongst mortals. Fear of travail is no exception. Lull and Hingson reported 4000 women willing to consider pregnancy and labor if assured they would have no pain. Two thousand para I women were reluctant to consider another pregnancy unless promised protection against pain, and this represents only a single observation. How many more women secretly harbor similar thoughts can never be known but may be guessed at by the fact that many women are more concerned about analgesia and anesthesia than about obstetrical care. Indeed, in spite of apparent interest in so-called natural childbirth today many women pick their obstetrician or hospital on the basis of type of pain relief offered. Adequate emotional preparation of the patient then becomes an important fundamental part of pain control during labor. Because this is so, it is imperative that we determine how this may best be accomplished. Briefly the following steps are important.

1. Individual or group discussions preferably beginning about the fourth or fifth month of gestation (time of quickening) on what pregnancy and labor are all about.
2. Introduction and instruction as to hospital, environmental surroundings, time factors in labor, duration, as well as subjective manifestations, of labor.
3. If the husband can attend these instruction periods, it is likely to help matters considerably.
4. If hospital care is planned, do not have the patient come to hospital in questionable labor sooner than necessary. A long hospitalization during the prodromal stage of labor can be both fatiguing and disconcerting.
5. The physician whom the patient has engaged for obstetric care should *himself* see and evaluate the patient's condition once labor has really begun. These evaluation visits should never be hasty, but thorough and as frequent as necessary for any given patient.

Much more could be said about each of these points but for purposes of this brief discussion they can only be mentioned.

Having received unhurried care and attention

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along the lines indicated above, one may be certain that the average normal woman will be no problem during the early stage of labor—either to herself or to the physician. One may be equally certain, however, that with progress and gradual dilatation of the cervix there comes a time when the average patient will welcome assistance to the extent of having the “sting” removed from the contractions. Obviously this time will vary considerably but is commonly noted at 3 to 5 cm. in primiparas and 5 to 7 cm. in multiparas. Again let me say that this is subject to a good deal of variation.

Accepting the fact that the patient is now actively in labor in the dilating stage—and uncomfortable—we are faced with the necessity for making two decisions: (1) shall we now resort to pain-relief measures, and (2) what shall we use?

The answer to the first question is easy. Those of us who have lived through a long period of medical practice would not care to return to the day when it was possible to learn much about the patient's status—even before entering the home or hospital—by the character of her outbursts. That type of delivery care was worrisome, wearisome and tough on the heart strings, but perhaps even harder on the patient. Points in its favor were the less frequent operative delivery and a seldom asphyxiated infant. Though generally safe, the early analgesia-less delivery care was not always so devoid of obstetrical trauma as has been commonly thought. Under duress of the moment patients were frequently prematurely urged to bear down, with resulting trauma—to cervix, vagina and perineum—of a kind we seldom see today. Furthermore, no one has yet satisfactorily evaluated emotional trauma of either the anesthesia-less confinement or present day pain-controlled labor.

Some obstetricians and many hospitals have developed pain relief in labor to the point where one may well inquire whether we have now reached the stage in our civilization where having a baby *without* pain control is about as obsolete as having an operation without anesthesia. Are we ready for obstetrical anesthesiologists? If the answer be yes, then anything short of complete pain relief during the entire birth process must be looked upon as inadequate. The answer to this question will obviously shape our plans for obstetrical pain relief. While the thought is intriguing, there are many reasons why we may be

certain the world has not yet reached such a millennium. A few reasons will suffice to clear the atmosphere on this point. (1) There is no such unanimity of opinion. Many, like Grantly Dick Read and his followers, hold a contrary view. (2) Many, perhaps one-half, of the babes are born at home. (3) Such a comprehensive program for obstetrical analgesia and anesthesia is as yet impractical. Any program for obstetrical pain relief then must fulfill certain requirements. Briefly, these may be stated as follows:

1. It must be safe for mother and child.
2. It must not interfere with the progress of labor.
3. It must adequately relieve suffering.
4. It should be practical.
5. It should not complicate labor and delivery by making the patient unduly restless or uncontrollable.

Since this is a practical problem the choice of drugs and technique is largely determined by such things as:

1. Place of delivery—home or hospital.
2. Availability and skill of attending physician.
3. Availability and skill of medical assistance (residents and nurses).
4. Parity of the patient.
5. Progress of labor.

All types of pain relief call for close supervision and the degree to which this can be given must influence the program for pain relief to be followed.

While we have devoted a fair portion of this discussion to generalization, I believe the points so far covered to be fundamental and an essential preliminary to any consideration of this subject.

It must be clear that the multiplicity of techniques available demonstrates convincingly that no one drug or technique is universally suitable or without drawback. Furthermore, the drugs which have been tried are so numerous that any attempt to consider them all at this time could only mean sketchy repetition of much that has already been published. Perforce then, we shall limit these remarks to consideration of a program for pain relief during labor, which, though flexible enough to meet varying practical restrictions, is nonetheless safe and reasonably adequate. Failure to mention certain drugs and techniques does not necessarily imply their undesirability. It is more likely to mean that in the program here outlined

PAIN RELIEF DURING LABOR—MILLER

our preference is for the drugs indicated. Finally, before outlining a suggested program, let me say that any plan for pain relief should be flexible enough to best meet the requirements of a given patient, and pain control by telephone is likely to be a poor substitute for relief under direct observation.

Here is the program we use:

1. *Prodromal Stage* (not certain patient is in labor).—Give reassurance. Stay at home and, if primipara and early at night, give one of the barbiturates such as Nembutal, grains iss to iii. If multipara, better come to hospital.

2. *Early Dilating Stage*.—Admit to hospital if patient is to be hospitalized. If primipara, careful examination and reassurance. At this time a simple explanation of what is taking place and what may be expected is both reassuring and appreciated by most patients. If at night, one of the shorter acting barbiturates such as Seconal, gr. iss to iii. If multipara, careful evaluation, reassurance, sedation. In primipara—when cervix is 3 to 5 cm. and patient actively in labor—arrange for darkening of room and quiet. However, some patients do better with diversion—music, reading, or visiting with husband. Tell patient what she may expect—not complete pain relief but removal of “sting” from contraction. May give Demerol 100 mg. intramuscularly with, or without, Scopolamine, grains 1/200 to 1/150. Demerol and Scopolamine may be repeated after a few hours. Patient to be carefully watched. Slower moving multiparas who are dilated only a few centimeters and uncomfortable may be managed in same way but watch for “sneak delivery.”

When cervix is 8 to 10 cm. in primipara (6 to 7 cm. in multipara) with patient in hospital and competent assistance available, regional analgesia (either saddle block or caudal) may be started. Since anyone using low spinal (saddle block) or caudal should be properly prepared by study and training, no attempt is made here to describe technique in detail. Reference is made to Lull and Hingson's book on *Control of Pain in Childbirth* and to a description of the original technique by Adriani and Parmley in *Southern Medical Journal*, 39:191, 1946, or to a report by Andros and Priddle on experience with “saddle block” anesthesia at the Chicago Lying-In Hospital.

In our own clinic both caudal and low spinal

have a useful place. During the past few years caudal or low spinal has been administered to over 5,000 patients. The quicker acting, shorter duration, low spinal (saddle block) has given satisfactory results, especially in multiparous patients. For primiparas, where more prolonged analgesia is desirable, the use of caudal technique has rendered acceptable relief from pain. Every patient managed by either one of these techniques should be in a hospital and under constant supervision of trained personnel. When fully understood and properly used, regional anesthesia of the types mentioned, especially when combined with preliminary sedation during the early stage of labor, offers the most complete and in some ways the most satisfying means of pain control during labor. In general, the low spinal technique used by us represents the original Adriani, Parmley technique as modified by Dr. George Andros. The caudal technique is that of Hingson and Edwards, as described in Lull and Hingson's book on *Control of Pain in Childbirth*.

It is well to keep in mind the contraindications to the use of regional anesthesia. Briefly these may be listed as follows:

1. Patients not in a hospital or in a hospital lacking trained personnel.
2. Some high strung, nervous individuals, including patients who fear the “needle.”
3. Patients with marked hypotension.
4. Cephalopelvic disproportion.
5. Placenta previa.
6. Premature separation.
7. Version and extraction for single fetus.
8. Active central nervous system disease of any kind.
9. Patients with history of migraine headaches.
10. Any patient where there exists doubt concerning the desirability of using regional anesthesia.

Since all patients are not suitable candidates for regional block, we return once again to the use of such oldtime standbys as ether, nitrous oxide-oxygen, or ethylene, for the terminal phase of labor. While these inhalants leave much to be desired, it should never be forgotten that they have brought comfort and solace to millions of women during labor. Remember, too, they are still good enough to be used regularly in all surgical fields and cannot yet, therefore, be labeled obsolete. Unless the complete requirements for the use of regional anesthesia can be met, we may without hesitation, and with a high degree of

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The Present Status of the Problem of Syphilis

By Louis A. Brunsting, M.D.
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THE INTRODUCTION of penicillin has revolutionized the management of syphilis in less than a decade. Little did Mahoney, Arnold and Harris² realize, when they demonstrated in 1943 that penicillin had treponemicidal effects on early syphilis in man, that repercussions would be felt so quickly and that penicillin would contribute so materially to reducing the incidence of the disease. Experts are now generally agreed, in this country at least, that, with rare exceptions, penicillin is entirely adequate to cope with all phases of syphilis from chancre to paresis.

Decline in Incidence of Syphilis

Statistical reports^{1,4,5} indicate a definite decline in the incidence of syphilis in this country, especially in early syphilis, since the postwar peak of 1947. This decline is not uniform in all the states, the incidence reflecting the socio-economic status of the area. The United States Public Health Service report showed that in 1947 there were 373,296 cases of syphilis reported; in 1949, there were 288,640. The number of instances of early syphilis discovered indicates the trend of the disease, even though it is estimated that half such cases are missed until the later stages of the disease, if they are found at all. Cases of early syphilis reported from Georgia in 1947 numbered 3,829; in 1949, 2,649. From Massachusetts in 1947, 903; in 1949, 337. From Minnesota, a low-prevalence area, only sixty-nine cases of acute syphilis were reported in 1949. In the larger cities of the country the same diminishing trend is evident. In Detroit, only 52 cases of early syphilis were reported in the first three months of 1950; in 1946, in the first three months, there were 545 cases. In Chicago, Ann Arbor and elsewhere, rapid intensive treatment centers have been discontinued, partly because of a decrease in case load, partly because of budget economies of local and federal governments. Paradoxically, there has been no decrease in the past five years in the

number of cases reported of congenital syphilis in the United States, the range being from 12,000 to 14,000 cases annually, with an actual increase during the past two years. In part, this increase may be explained on the basis of more intensive efforts at case-finding in screening surveys in neglected areas; in part, this may be an aftermath of the increased incidence of early syphilis during the war years, many instances of which were not recognized or perhaps received inadequate treatment and relapsed.

Penicillin does not deserve the whole credit for the diminishing incidence of syphilis in recent years, for the same decline has been noted in post-war years in certain foreign countries where penicillin was not generally available. In the United States the mortality rate of syphilis has been halved in the decade 1938 to 1948. There has been a steady decline in deaths from cardiovascular syphilis and general paresis, in the latter instance since the introduction of malaria therapy in 1923.

The crux of the situation in the control of syphilis is to discover the patient who has syphilis and, of course, the earlier the better. Campaigns of public education and the use of screening surveys of the population have merit, but we should expend more effort in the training of medical students and younger practitioners of medicine in the fundamental aspects of syphilis and teach them to think of syphilis in dealing with their patients so that they will make more liberal use of available laboratory facilities. It is estimated that about a third of the patients with early syphilis that is recognized are under the care of private practitioners. Too often such patients are not reported to health authorities for fear of disclosure. Records indicate that physicians are notoriously remiss in checking the contacts of private patients who have early syphilis, and to that extent they are guilty of abetting a crime.

Treatment of Syphilis with Penicillin

Once the diagnosis of syphilis has been made and treatment is found necessary, penicillin is the agent of choice. I say "and treatment is found necessary," because of the widespread tendency to treat results of the patient's serologic tests rather than the patient himself. In the case of individuals with latent syphilis who have had adequate treatment previously, and especially in the elderly, there is nothing to be gained by

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pressing the issue solely because of seroresistance. Time is a great healer. We must not lose sight of the fact that the patient who has late latent syphilis, even when untreated, stands a three-to-one chance of living his normal expectancy without the development of serious complications of the disease.

Physicians have a choice of types of penicillin to be used; repository forms are in favor because of convenience and economy in permitting the patient to remain ambulatory. Procaine penicillin G in aqueous suspension is the preparation of choice at present, and probably will supplant all other forms. Newer antibiotic agents, such as aureomycin and chloramphenicol, eventually may replace penicillin in the treatment of certain phases of the disease, but for the present their use should be confined to conditions under experimental control. Of the older forms of treatment, bismuth finds some usefulness in selected cases, but it is the consensus of most experts that the arsphenamines are obsolete.

The chief advantage of penicillin in the management of early syphilis, aside from the insignificant cost of the drug, the fact that it is nontoxic and the fact that by the use of repository preparations patients may be ambulatory, is that more than 95 per cent of the patients receive an adequate amount of treatment. In the old days, with long schedules of arsphenamine and bismuth given over a period of two years, less than 30 per cent of this group finished the minimal requirements of adequate treatment. Furthermore, when penicillin is used, the danger of neurosyphilis is practically abolished, a feature which is bound to have far-reaching significance in the future trends toward the development of tabes dorsalis and paresis.

In the discussion of particulars of treatment, I shall emphasize those phases of syphilis which are most common and represent the chief problems of the general practitioner, and shall leave the controversial issues to the consideration of authorities in this field.

Early Syphilis.—This includes primary syphilis, both seronegative and seropositive, secondary syphilis and early latent syphilis during the first four years of the infection. In general, it is the custom, except in the face of obvious signs of congenital syphilis, to include in this group all patients under the age of thirty years who are

found to have latent syphilis. The remarkable results of penicillin in the treatment of syphilis are most vividly expressed in the high percentage of cures that are obtained in the treatment of early syphilis. In the primary seronegative phase, the results are practically perfect. The older the disease, the higher is the percentage of serologic and clinical relapse, ranging from 10 to 20 per cent of patients treated in the late secondary phase, which emphasizes the need for constant vigilance in the follow-up of such patients and the use of quantitative procedures for serologic testing at frequent intervals. The cerebrospinal fluid should be examined early and again before the patient is considered cured.

Ideal schedules of treatment within certain limits still are more or less arbitrary. In urban centers with a floating population, it may be wise to give large initial doses so that if patients lapse from treatment, there will be less chance of relapse of the disease. In general, in the group of patients who have early syphilis, it will be safe to give 600,000 units of penicillin (procaine penicillin G in aqueous suspension) by intramuscular injection daily for fifteen consecutive days. In the secondary stage and in the relapsing stages, when retreatment is needed, the total dose should be larger. The addition of arsphenamines or bismuth to such schedules does not contribute to the effectiveness of therapy.

An interesting development has been the prophylactic treatment with penicillin of persons who have had contact with patients with infectious syphilis, even though examination shows no signs of the disease. Early reports indicate that the incidence of syphilis developing in such contacts has been reduced from a range of 25 to 60 per cent in the untreated, to 4 per cent among those given treatment.

Late Latent Syphilis.—The diagnosis, latent syphilis, assumes that the patient shows only serologic evidence of the disease in the blood, that the cerebrospinal fluid is normal and that there is no evidence of cardiovascular or other visceral involvement. The question of a biologic false positive reaction must be settled in every instance before treatment is begun. It is important to discuss thoroughly the nature of the problem with the patient before treatment and to decide in each case whether treatment is necessary, to emphasize that serologic reversal is not the chief

aim of the treatment and that such changes may require five years or more to become apparent. If this is not done, such patients will become syphilophobic and will interpret every slight symptom—sore throat, aching muscles, headache and so forth—in terms of syphilis.

The average patient who has late latent syphilis will receive adequate protection from one course of penicillin, 6,000,000 units given over a period of twenty days. Periodic physical examinations at yearly intervals thereafter should be the rule.

Syphilis in Pregnancy.—Penicillin therapy administered to pregnant syphilitic women is practically 100 per cent effective in preventing congenital syphilis, even when treatment is given in the third trimester or near term. By older methods, not considering the toxic reactions and those who lapsed from treatment, there was a failure rate twice that associated with the use of penicillin when treatment was given before the fifth month of pregnancy, and six times higher than that accompanying the use of penicillin when treatment was not instituted until late in pregnancy. It is important to remember that infectious syphilis in pregnant women who are treated with penicillin early in the course of pregnancy may relapse, or reinfection may develop before term. Periodic re-examinations at monthly intervals should be maintained in such cases.

Experience in the Detroit Clinics indicates that pregnant women who have received adequate treatment for syphilis before pregnancy may be safely permitted to carry on without additional treatment and with no hazard to the child. The percentage of stillbirths and other accidents of pregnancy is no higher in penicillin-treated pregnant women with syphilis than in members of control groups without syphilis. Pregnant mothers with syphilis should receive a minimum of 4,000,000 units of penicillin, and perhaps more. I would suggest the use of 600,000 units daily for ten consecutive days.

Congenital Syphilis.—Penicillin likewise is effective in the treatment of congenital syphilis, the incidence of good results being significantly better among children treated before the age of six months than among those treated later. It is not necessary to review the clinical signs of congenital syphilis, except to emphasize a few points when

diagnosis is made on serologic evidence alone. Serologic examination of the cord blood at the time of delivery is of practically no value in clearing up the issue of syphilis in the mother or in the child, and a diagnosis never should be made on this basis alone. It is possible for syphilitic reagin to pass through the placenta from the mother to the child without infection of the child being accomplished. Unless there are actual signs of congenital syphilis, a positive result of a serologic test of the child within the first few weeks after birth should cause the test to be repeated one month later and again after another month, and if the quantity of the titer diminishes, treatment should be withheld. On the other hand, if the mother has active syphilis, untreated, and the serologic reaction of the child shows a significant positive reaction, there is less harm in giving the child treatment with penicillin as a prophylactic measure than was formerly the case when the older and more ineffective measures of treatment were the only procedures at our command.

The dose of penicillin in the treatment of congenital syphilis is usually judged by the body weight of the child, and should consist of 100,000 units of penicillin per kilogram of weight, given over a period of fourteen to twenty-one days.

Penicillin alone is ineffective in the control of congenital syphilis with interstitial keratitis. In such cases ophthalmologic consultation is essential, and supplemental measures of treatment, such as fever, should be administered before there has been permanent damage to the eyes. Recent observations indicate that the use of cortisone and ACTH may help to control the inflammatory phase of acute interstitial keratitis; these promising results at present are being explored.

Late Benign Syphilis.—Adequate treatment of syphilis in the early or latent stages will prevent the development of the visceral complications of the disease. Gummatous lesions of vital structures, the liver, brain and stomach, are relatively rare; at present, few patients with the familiar nodulo-ulcerative syphiloderm reach university clinics or other diagnostic centers without having received the ubiquitous penicillin elsewhere, and there is a paucity of such material for teaching purposes. The response of such lesions to penicillin is dramatic, although positive serologic reactions may persist in the blood for years. Patients who

have late benign syphilis may be given an initial course of penicillin until a total of 4,800,000 to 6,000,000 units has been reached, and then may be placed on observation as is done in the case of late latent syphilis.

Cardiovascular Syphilis.—The diagnosis of uncomplicated syphilitic aortitis puzzles the expert cardiologist. It is rarely justified on the basis of clinical evidence alone, according to my medical colleagues. In the presence of aortic insufficiency or aneurysm, and especially in the face of decompensation, emphasis should be on maintaining cardiac reserve by conventional methods rather than to turn first of all to measures of specific treatment for syphilis. Penicillin may be given in such cases without fear of untoward reaction; schedules of dosage at present are entirely arbitrary, and the results of treatment must be calculated in terms of years. A decline in the death rate from cardiac syphilis occurred long before the introduction of penicillin.

Neurosyphilis.—Syphilis of the nervous system can be prevented. Tabes dorsalis and general paresis are the development of an asymptomatic process laid down in the nervous system during the early infectious stages of the disease, ten to twenty years before clinical signs of damage to cord and brain become apparent. It was estimated five years ago that it costs \$11,000,000 a year to support parietic persons in mental hospitals in this country, and \$4,000,000 a year to support the syphilitic blind, not to mention the tremendous loss of income sustained by these disabled persons. Neurosyphilis will never be abolished so long as there is a vast reservoir of candidates provided by the thousands whose syphilis is unrecognized and untreated in the early stages of the disease.

On the other hand, a number of factors have been working toward the reduction in incidence of the late phases of neurosyphilis, and this trend may be expected to increase considerably in decades to come. Today, the incidence of neurosyphilis in penicillin-treated patients with early syphilis is almost negligible, and case-holding is excellent, in contrast to the arsphenamine-bismuth era, when so few patients finished minimal therapeutic requirements. Also, the alert physician is making more use of diagnostic lumbar puncture in appraising apparently late benign syphilis be-

fore treatment. Even unrecognized asymptomatic neurosyphilis is bound to benefit by the widespread use of penicillin, whether directed blindly to a patient who has a persistently positive reaction to a serologic blood test for syphilis or employed in the treatment of some intercurrent infection for which the use of penicillin seems indicated.

Before discussing the treatment of neurosyphilis, I should like to discuss examination of the cerebrospinal fluid. It is trite to remark that every patient with syphilis should have an examination of the cerebrospinal fluid, preferably before treatment, or early in the course of treatment, in order to establish a base line and as a guide to prognosis and treatment. Abnormal findings in the cerebrospinal fluid, even without the presence of clinical signs of neurosyphilis, call for a much more intensive program of treatment and follow-up than when the disease is uncomplicated. Examination of the cerebrospinal fluid should be omitted in cases in which another medical problem is paramount, such as bleeding peptic ulcer, a malignant lesion or advanced cardiovascular disease, or when the patient is more than sixty years of age and the history of syphilis dates back twenty-five or thirty years, unless a puzzling diagnostic problem or signs and symptoms indicating active parenchymatous neurosyphilis are present. The examination in question should be postponed during a patient's pregnancy.

In examination of the cerebrospinal fluid, the features to be emphasized are the cell count, the total protein, the serologic reaction and the colloidal-gold curve. The most important of these is the cell count, done on a fresh, not a mailed, specimen. If the cell count is normal and the content of total protein is less than 50 to 60 mg. per 100 c.c., it may be assumed that there is no activity in the nervous system.

In the treatment of neurosyphilis, fever has been largely superseded by penicillin. The appraisal of therapeutic results in neurosyphilis is a long-term affair and requires more than the five years that have passed since penicillin was introduced. However, the statistics available indicate that except in the case of general paresis, the combination of penicillin plus fever has no advantage over the use of penicillin alone in adequate doses, and in the latter case, the risk of fever therapy is eliminated. Malaria and other forms of fever are now

generally reserved for those patients with active paresis or those whose syphilis is resistant to penicillin or has relapsed, or who are penicillin-sensitive. The use of newer antibiotics, such as aureomycin and chloramphenicol, is being explored; early reports indicate that they are effective in the control of syphilis. If they eventually establish themselves, they may simplify the problem of treatment still further, for they may be administered orally and are relatively non-toxic.

The exact schedule of dosage for the treatment of neurosyphilis by penicillin is not yet established; generally a larger dose than average should be administered over a longer period. The danger of occurrence of a Herxheimer reaction is insignificant. For patients previously untreated, and in asymptomatic and meningovascular neurosyphilis, the first course should comprise a total of 9,000,000 units administered in a period of twenty-one days. In the presence of tabes or paresis, the dose should be larger: 10,000,000 to 15,000,000 units. Progress is determined by the clinical response and by the record of changes in the cerebrospinal fluid, which is examined at intervals of four to six months. Decisions regarding details of treatment and the management of complications of neurosyphilis comprise a chapter in themselves. Treatment should not be continued indefinitely. When the disease has produced structural damage to the nervous system, the changes are irreversible.

Reactions to Penicillin

Local reactions at the site of intramuscular injections occasionally occur, but they are infrequent when aqueous suspensions of procaine penicillin G are substituted for the older oil-in-wax preparations. Vesicular dermatitis may appear in the course of the lighting-up of a previous fungous infection of the skin on the feet, groin or hands; sites previously sensitized by topical applications of penicillin to the skin will flare after the intramuscular injection of penicillin. Usually these reactions are mild, but occasionally they lead to universal exfoliative dermatitis.

The most common reaction to penicillin is urticaria, which generally appears seven to ten days after the initial injection and may assume all the qualities of serum sickness, with angioneurotic edema, fever and pains in the joints. The symptoms may be controlled by the intramuscular

injection of ACTH (adrenocorticotrophic hormone) or cortisone for a few days. Antihistaminic drugs as a rule are ineffective. In most patients, treatment with penicillin may be continued without interruption. In cases of extreme sensitivity, other antibiotic agents, such as aureomycin, may be substituted.

Research in Syphilis

Virulent *Treponema pallidum* has not yet been grown in pure culture, although viable organisms can be maintained for some time under special anaerobic conditions. The electron microscope has resolved to some extent the pattern of the organism in respect to cell membrane, flagella and buds. Studies with phase microscopy and with special staining techniques indicate that *Treponema pallidum* has a complicated life cycle, with reproduction occurring by transverse division and by the production of gemmae or buds. Cystic forms become more numerous when conditions of growth no longer are optimal. It is entirely possible that the prediction of Warthin forty years ago, concerning the existence of granular or resting forms of the organism, may be substantiated.

Recent studies in experimental syphilis in rabbits have been devoted to observations on penicillin-resistance under various schedules of treatment, and to the behavior of the pattern of acquired immunity that appears with the passing of time. The reaction of tissues to inoculation with *Treponema pallidum* varies considerably with the host. In the mouse practically all tissues are resistant, although lymph nodes of infected mice can almost always transmit the infection to other animals. In the rabbit only the testes, eyes, skin and bones react with lesions. In man, no tissue is immune except to a relative degree. This means that the thyroid parenchyma, pancreas, kidney, ovary and body of the uterus usually are spared.

An important contribution to fundamental studies in the biology of syphilis in animals and man is the recent demonstration by Nelson and Mayer³ of a specific antibody in syphilitic serum which, in the presence of complement, exerts a marked immobilizing influence on *Treponema pallidum* in vitro. The effect is absent from normal serum and is irregular in the primary stage of syphilis. The antibody is distinct from the syphilitic reagin. The use of the immobiliza-

SYPHILIS—BRUNSTING

tion test may be of great practical importance in clearing the issue in cases of so-called biologic false-positive reactions for syphilis, and in the study of immune reactions.

Control of Syphilis

A reasonable degree of optimism is justified when we consider the gains accomplished in the problem of syphilis in less than a decade. There never can be complete control of the disease, however, so long as more than half the instances in the communicable phase are not apprehended until more than a year after the onset of the infection. It is estimated that 3,000,000 persons in this country have a positive reaction to a serologic test for syphilis; the fact that the disease each year maims thousands and infects others innocently is a sobering thought.

In 1936 the activities of the United States Public Health Service were vitalized by Thomas Parran toward the control of venereal disease on a national scale. Throughout the years these efforts have brought dividends in stimulating research, educating the public and in providing financial subsidy and personnel to local and state units to assist in case-finding and to institute facilities for treatment on a wholesale scale. If these energies are curtailed, much of these gains will be lost. There is always an upsurge of the communicable stage of venereal disease during conditions of social unrest that attend mobilization and war. It behooves us as physicians to maintain a constant interest in these matters, so that progress shall not be nullified by shortsighted economies of budget in the field of public health.

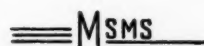
Summary

Some of the factors which have contributed in recent years to a decline in the incidence of syphilis are discussed. Even though the magic of penicillin has provided a safe and economical form of treatment, the keynote of control of syphilis is the recognition and care of patients who have early stages of the disease as well as thorough investigation of contacts that have been exposed. It is the responsibility of the physician to consider the possibility of syphilis in every pregnant woman; congenital syphilis can be entirely prevented. Practical points in the diagnosis and management of the various phases of syphilis, of interest to the general practitioner rather than

the specialist, are emphasized and optimal schedules of therapy are outlined.

References

1. Beerman, Herman; Nicholas, Leslie; Buerk, Minerva S., and Ford, W. T.: Syphilis. A review of the recent literature. *Arch. Int. Med.*, 85:305-358 (Feb.); 496-541, (Mar.); 699-721, (Apr.); 819-886, (May) 1950.
2. Mahoney, J. F.; Arnold, R. C., and Harris, Ad: Penicillin treatment of early syphilis. A preliminary report. *Ven. Dis. Inform.*, 24:355-357, (Dec.) 1943.
3. Nelson, R. A., Jr., and Mayer, M. M.: Immobilization of *Treponema pallidum* in vitro by antibody produced in syphilitic infection. *J. Exper. Med.*, 89:369-393, (Apr. 1) 1949.
4. Thomas, E. W.: Syphilis: Its Course and Management. 317 pp. New York: The Macmillan Company, 1949.
5. WHO Syphilis Study Commission: Venereal-disease Control in the United States, With Special Reference to Penicillin in Early, Prenatal, and Infantile Syphilis. Technical Report Series 15, Geneva, World Health Organization, May, 1950. 69 pp.



OVERCOMING HEMORRHAGIC PUERPERAL MORTALITY

(Continued from Page 40)

blood, according to the estimate of probable requirements.

In undertaking major surgery, venoclysis should be started before the operation, and necessary quantities of suitable blood should be actually in the operating room, to be quickly substituted at need for the other liquid already flowing into the patient's veins.

If the surgery is performed for actual hemorrhagic emergency, adequate transfusion to insure operability must be administered *before* the operation is performed, and continued during and after operation as the situation demands.

My subject might well be expanded in many important regards. But if doctors will be alert to detect the possibility or actuality of hemorrhagic danger, if they will insist on the provision of adequate organization in their environment for meeting this danger, and will promptly and adequately avail themselves of those facilities, deaths from hemorrhage everywhere will be greatly reduced, and we may come very close to Stallworthy's ideal of no deaths from puerperal hemorrhage.

References

1. U. S. Bureau of Census: 16th Census. U. S. Government Printing Office, 1943.
2. U. S. Vital Statistics, 1947.



Treatment of Eczematous Dermatoses

The Topical Use of an Antihistamine Agent Combined with Chloriodohydroxyquinoline

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THIS REPORT deals with the combined topical use of two valuable agents in the treatment of eczematous skin eruptions. The effectiveness of chloriodohydroxyquinoline and pyranisamine maleate, an antihistaminic drug, combined in a bland, non-greasy vehicle* has been striking enough to warrant a summary of the results observed in cases of atopic dermatitis, contact dermatitis and other eczematous eruptions. Each of these drugs prepared alone in a suitable base has proven in our own experience, as well as in that of others,^{2,5,7,8} to be valuable local medicaments in dermatologic therapy. The two drugs employed together, however, in many instances in the present study, have been observed to accomplish a more desirable effect than either one alone.

Chloriodohydroxyquinoline in 2 or 3 per cent concentrations exhibits bacteriostatic and fungostatic properties, and has been widely used in the local treatment of atopic, contact, and seborrheic dermatoses, sycosis barbae, stasis dermatitis, bacterial and mycotic infections of the skin, pruritus ani and vulvae, and psoriasis. Its low sensitization index and relatively non-irritating qualities have given it a position high on the list of effective dermatologic agents. One disadvantage in its use is the tendency to stain the skin and clothing yellow. This is less marked when the drug is combined in a water-miscible rather than an oily base. In the present study, chloriodohydroxyquinoline was used in a 3 per cent concentration.

The antihistamine agents in the relatively short time since their introduction have earned an important place in the therapeutic regimen of pruritic dermatoses, especially in those cases where allergy plays a significant role. The effectiveness

of oral preparations in reducing edema and in alleviating pruritis is well known. Their usefulness in topical therapy has also been recognized, and many of these compounds have been prepared in concentrations of 2 to 5 per cent in both water-miscible and oily bases for the treatment of dermatologic conditions. In addition to the marked ability of these drugs to antagonize the physiologic effects of histamine, they also exhibit strong local anesthetic properties which are to some degree responsible for their effectiveness in pruritic dermatoses. Their ability to penetrate the skin when applied in appropriate vehicles has been demonstrated.³ There is some laboratory evidence that they may act as fungostatic agents,¹ and certain members of the group are effective sun-screens, hindering the passage of the erythema-producing rays of the spectrum.⁴ Pyranisamine maleate, which is dimethylaminoethylmethoxybenzylaminopyridine, is an unusually strong antagonist of histamine, and ranks high among the available antihistamine preparations in point of therapeutic effectiveness, both in the case of oral administration and topical application. Our own experience has shown that a 2 per cent preparation in a water-miscible cream exerts a high degree of antipruritic action with a minimum of irritation when applied to acute, subacute, and chronic eczematous eruptions. This strength of antihistaminic drug was used in the combination under study.

The appropriate vehicle for dermatologic therapy must of necessity vary with the type of condition under treatment. In any case, the base employed must be nonirritating and of a low sensitizing potential. In the local treatment of eczematous eruptions, it has been our impression that medicaments prepared in water-miscible bases are more effective and less irritating than when employed in greasy vehicles. The base used to incorporate the active ingredients under study consisted of a water-washable ethylene glycol stearate dispersion in methoxycellulose gel which in itself appears to exert an emollient action. To overcome the dry, water-repellent properties of chloriodohydroxyquinoline and to insure thorough contact with the skin, a bland effective wetting agent of the sodium sulfosuccinate type (1 per cent aranol penetrant — C & M) was included in the base. When this preparation resulted in excessive drying, or when the necessity for greater lubrication was apparent, an ointment base was substituted. Occasionally the use of a water-washable cream dur-

*The combination under the trade name of *Quinamine Cream* was supplied for this study by the C & M Pharmacal Co., Detroit, Michigan.

ing the day, and a more lubricating ointment at bedtime was found to be a desirable combination.

Wherever possible, the effectiveness of the various ingredients alone, as well as in combination, was evaluated in the same patient. Sometimes it was possible to accomplish this by treating separate skin areas simultaneously with the various preparations. In other cases, they were used alternately. The cream was used in acute, subacute, and chronic cases two or three times daily. In most instances a program of avoidance of known allergens, and desensitization therapy to specific inhalant allergens was carried out in addition to topical therapy. In the case of acute eruptions, boric compresses or wet dressings of Burow's solution were used, and the combination cream employed between the moist applications, and at bedtime. In subacute and chronic stages, the preparations under study were the sole topical medications.

Results

Fifty-seven patients in the following categories were treated with the combination cream (Table I).

Condition Treated	No. of Patients	Improved	Not Improved	Aggravated
Atopic dermatitis				
Adults and older children.....	32	31	1	0
Infants	9	7	2	0
Contact dermatitis.....	9	7	0	2
Infectious eczematoid dermatitis	3	3	0	0
Stasis dermatitis.....	2	2	0	0
Dermatitis herpetiformis.....	1	0	0	1
Nummular eczema.....	1	1	0	0
Total	57	51	3	3

Atopic Dermatitis.—Thirty-two patients, comprising older children and adults, who were given the medication for local therapy were benefited. One was not improved. The antipruritic effect was rapid in onset, and a marked improvement in the appearance of the skin frequently occurred during the first twenty-four hours. Good results were also seen in some of these subjects from the use of the individual ingredients in the emollient base, but the combination of the two active substances proved more consistent in relieving pruritus and promoting healing of the active dermatitis. In the acute phases of the eruption, the use of local medication between moist compresses was found eminently satisfactory, and enhanced the remission. Excellent effect was observed in subacute phases. In the chronic, lichenified, excessively dry phases, it was often necessary to use the active ingredients in a more lubricating base.

In a group of nine infants and younger children, all under the age of five years, striking improvement occurred in seven cases following the use of the combination cream. Relief of pruritus with subsequent reduction of scratching was the most consistent observation. In two youngsters, ages three and four years, no improvement occurred.

Contact Dermatitis.—Nine patients with acute eczematous contact-type dermatitis in whom the specific allergen had not yet been identified were treated with the combination cream. In some instances this was the only medicament employed. In other cases the cream was alternated with moist compresses. In seven cases this therapy was extremely beneficial in controlling the eruption until the specific sensitizing factor could be identified and eliminated. In the two remaining patients, the use of the cream definitely aggravated the condition. One of these was a seventy-two-year-old woman with a dry senile skin, and the other a thirty-eight-year-old woman with a dermatitis of the hands and forearms who was also aggravated by each ingredient alone, as well as by calamine lotion, Burow's solution, and Lassar's paste.

Miscellaneous Eczematous Eruptions.—The combination cream was found extremely helpful in three cases of infectious eczematoid involvement of the external auditory canal; in two patients with stasis dermatitis of the legs; and in one case of nummular eczema involving the hands. One patient with dermatitis herpetiformis was made worse by the medication. Further investigation showed this to be caused by the chloriodohydroxyquinoline. The antihistaminic drug and emollient base were well tolerated. In view of the common association of iodide sensitivity in this condition, aggravation of the lesions by the combination cream might at first seem not at all unexpected. However, the iodine fraction of chloriodohydroxyquinoline is held in close combination, and little if any is apparently released. The use of chloriodohydroxyquinoline in patients with dermatitis herpetiformis without aggravation, and with improvement of the lesions has been reported.⁶

Discussion

Because of the many factors involved in atopic dermatitis, contact dermatitis, and the other eczematous eruptions discussed, it cannot be anticipated that topical therapy alone will cure these

conditions. Excellent results are frequently obtained in these situations by careful allergic investigation with subsequent control of the specific sensitizations responsible for the dermatitis. Local therapy, however, is often necessary to control pruritus, and may help to induce a remission. The use of appropriate local medication to improve the character of the skin and to afford symptomatic relief together with efforts to control specific sensitizing factors offers the best opportunity for rapid relief and ultimate cure of the condition. Aggravation of the skin is frequently seen following the use of local medication, and the choice of materials for topical therapy must therefore be selected with some care. Both pyranisamine maleate, 2 per cent, and chloriodohydroxyquinoline, 3 per cent, as well as the emollient base in which they were combined, are bland and relatively nonirritating substances, even when used in acutely inflamed skin. Many of the patients in this series who have used a great variety of local medicaments during the period of their difficulty, in some instances extending over a period of years, remarked that the combination cream was the most satisfactory preparation they had yet encountered.

Summary

1. Pyranisamine maleate, 2 per cent, and chloriodohydroxyquinoline, 3 per cent, combined in a bland water-miscible base, were employed in the local treatment of eczematous dermatoses.

2. Marked relief of pruritus and improvement in the appearance of the skin was observed in thirty-two adults and older children with atopic dermatitis. Seven infants and younger children with atopic eczema were similarly benefited, while two others were not appreciably helped. In seven cases of acute eczematous contact-type dermatitis, the combination cream proved extremely helpful. An excellent response occurred in three cases of infectious eczematoid involvement of the external auditory canal, in two patients with stasis dermatitis of the legs, and in one case of nummular eczema.

3. Aggravation of the skin eruption was seen in two individuals with eczematous contact-type dermatitis, and in one patient with dermatitis herpetiformis.

4. Each of the major ingredients of the preparation studied is a valuable local medicament in the treatment of pruritic eczematous dermatoses. The combination of the two drugs in a bland wa-

ter-miscible base appears to accomplish a more desirable effect than either one alone.

References

1. Carson, L. E., and Campbell, C. C.: The inhibitory effect of three antihistaminic compounds on the growth of fungi pathogenic for man. *Science*, 3:689, 1950.
2. Feinberg, S. M., and Bernstein, T. B.: Tripelenamine (Pyribenzamine) ointment for the relief of itching. *J.A.M.A.*, 134: 874, 1947.
3. Friedlaender, S., and Friedlaender, A. S.: The effect of an antihistamine agent on various whealing phenomena. *Rev. mex. de Alerg.*, 1:14, 1949.
4. Friedlaender, A. S.; Friedlaender, S., and Vandenbelt, J. M.: Spectral absorption characteristics of antihistaminic drugs; relationship to ultraviolet erythema. *J. Allergy*, 20:229, 1949.
5. McGavack, T. H.; Schulman, P.; Schutzer, R., and Elias, H.: Effects of topical applications of diphenhydramine hydrochloride (Benadryl). *Arch. Dermat. & Syph.*, 57:308, 1948.
6. Overton, J.: The topical use of vioform in dermatology. *Brit. M. J.*, 1:840, 1949.
7. Reque, P. G.: The use of vioform ointment in dermatology. *Mississippi Doctor*, 25:203, 1947.
8. Sulzberger, M. B., and Baer, R. L.: Vioform in dermatologic therapy. *Arch. Dermat. & Syph.*, 58:224, (Aug.) 1948.

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EFFECT OF PREGNANCY ON THE URINARY TRACT

(Continued from Page 44)

Summary

The physiological changes in the upper urinary tract as they occur during pregnancy have been described and the present concepts regarding their cause have been related. Studies have been enumerated and treatment suggested for renal pain, pyuria and hematuria as they are manifested during pregnancy.

References

1. Crabtree, E. G.: *Urological Diseases of Pregnancy*. Boston: Little Brown and Company, 1942.
2. Crabtree, E. G., and Prather, G. C.: Urinary diseases in pregnancy. *J. Urol.*, 26:499, 1931.
3. Crabtree, E. G.: Hydroureter of pregnancy. *J. Urol.*, 38:605, 1937.
4. Prather, G. C.: The effect of changes due to pregnancy on urinary tract diseases. *New England J. Med.*, 205:1051, 1931.
5. Prather, G. C.: Results of sulfanilamide therapy in urinary tract infections of pregnancy. *New England J. Med.*, 221:6, 1939.
6. Prather, G. C., and Sewall, W.: Relation of pyelonephritis to toxemias of pregnancy. *Tr. Am. A. Genito-Urin. Surgeons*, 33:61, 1940.
7. Rayer, P. F. D.: *Traite des Maladies des Reins*. Vol. 1. Paris: J. B. Bailliere, 1839.
8. Robertson, H. E.: *Hydroureter and Pyelitis of Pregnancy*. Philadelphia: W. B. Saunders Company, 1944.
9. Trout, H. F., and McLane, C. M.: Physiological changes in the ureter associated with pregnancy. *Surg., Gynec. & Obst.*, 62:65, 1936.
10. Trout, H. F.; McLane, C. M., and Kuder, A.: Physiological changes in the ureter associated with pregnancy. *Surg., Gynec. & Obst.*, 64:51, 1937.
11. Van Wagenen, G., and Jenkins, R. H.: An experimental examination of factors causing ureteral dilatation of pregnancy. *J. Urol.*, 42:1010, 1939.
12. Van Wagenen, G., and Jenkins, R. H.: Pyeloureteral dilatation of pregnancy after death of the fetus. *Am. J. Obst. & Gynec.*, 56:1146, 1948.
13. Weiss, S., and Parker, F.: Pyelonephritis. *Medicine*, 18:221, 1939.

Angiocardiography in the Differential Diagnosis of Mediastinal Pseudo-tumor

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WITH THE use of angiocardiography, many bizarre shadows simulating mediastinal tumors are easily clarified. We recently encountered one such case in which a posterior mediastinal shadow due to cardiovascular overlapping was present in the left anterior oblique position and simulated a mediastinal tumor.

Some of the conditions which might simulate mediastinal tumors on roentgen examination are scoliosis of spine, esophageal cardiospasm, paravertebral abscess, cardiac aneurysm, pericardial cyst, tumor or diverticulum, and mediastinal and interlobar effusions. With conventional fluoroscopic and radiographic technique scoliosis of the spine, cardiospasm and paravertebral abscesses can be diagnosed and excluded. Special positions, such as lateral decubitus, and lordotic views will enable one to resolve the mediastinal and interlobar effusions. In cardiac aneurysms and cardiovascular overlapping, kymography and angiocardiography are of value.

Cardiovascular overlapping may also produce a confusing posterior mediastinal shadow in the left oblique projection as will be demonstrated in the case to be reported. An enlarged left ventricle overlapping a tortuous and widened, or even aneurysmal, descending aorta may demarcate an oval shadow of increased density which will appear to lie adjacent to or posterior to the cardiac silhouette in the left oblique position. In the conventional postero-anterior projection this shadow is usually not visualized. An aneurysm of the descending aorta alone will as a rule project beyond the vertebrae into the surrounding illuminated lung parenchyma.

Case Report

C. P., a sixty-one-year-old white male tool grinder, was first seen by us on March 30, 1949, complaining of intermittent episodes of paroxysmal nocturnal dyspnea of two years' duration. The past history included a hemorrhoidectomy and left inguinal hernioplasty in 1939,

the passage of a left ureteral calculus in 1943, and the removal of a foreign body from the heart in February, 1947.

In 1947 while the patient was at work, a piece of steel broke off the material he was grinding and penetrated his chest, entering the left ventricle. An operation was performed at a local hospital where the piece of steel was removed and the laceration of the heart was repaired. Since this accident, the patient had occasional episodes of paroxysmal nocturnal dyspnea and attacks of irregular cardiac palpitation. Other elements in the history were not pertinent. Patient denied any history of syphilis or its manifestations.

Physical examination revealed a surgical scar in the left fifth intercostal space anteriorly. The heart was enlarged to the left with the point of maximum impulse at the left anterior axillary line in the sixth left intercostal space. The sounds were of fair quality with a loud, booming aortic second sound. There were long, loud, blowing systolic and diastolic murmurs audible at all valve areas, but loudest at the base. Rhythm was of regular sinus origin with occasional premature contractions. The blood pressure was 200/100. Physical examination was otherwise not remarkable.

X-ray examination of the chest in the postero-anterior projection revealed enlargement of the heart in its transverse diameter with marked widening and tortuosity of the aorta. There was linear calcification in the aortic knob. The bronchovascular markings were somewhat exaggerated throughout both lung fields.

Urinalysis was not remarkable except for a very faint trace of albumin. The hemoglobin was 17.2 grams per 100 c.c. The blood Kahn test was negative. An electrocardiogram revealed the pattern of left ventricular hypertrophy and occasional ventricular premature contractions.

Fluoroscopic examination of the chest revealed aneurysmal dilatation of the ascending aorta, and left ventricular hypertrophy.

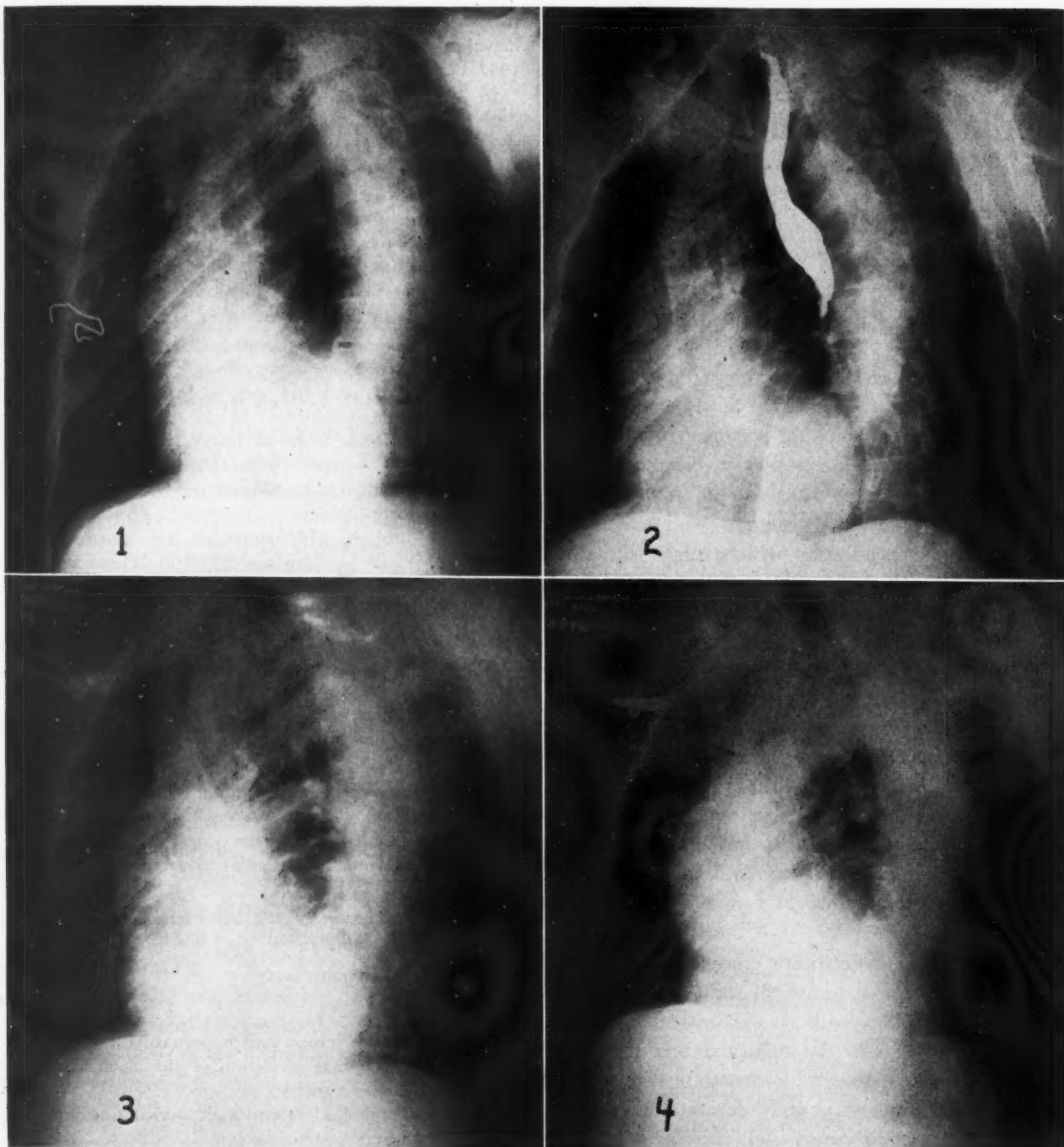
The clinical diagnosis was:

Heart Disease

- A. Arteriosclerotic and hypertensive.
- B. Aneurysmal dilatation of the aorta, left ventricular hypertrophy.
- C. Functional aortic and mitral insufficiency, cardiac insufficiency.
- D. Class III C.

In Figure 1, which was taken in the 45-degree left anterior oblique position, an oval shadow of increased density simulating a mass was seen overlapping the left ventricle and dorsal spine. Fluoroscopic examination revealed no evidence of mass; the left ventricle was enlarged and the ascending aorta exhibited aneurysmal dilatation. There was no evidence of paradoxical pulsations. A barium esophagram revealed a tortuous descending aorta displacing the esophagus anteriorly (Fig. 2). Angiocardiography was performed with 70 per cent Diodrast solution. In view of the prolonged circulation time in this patient the film at 7.5 seconds (Fig. 3) demonstrated the contrast medium in the right heart and in the pulmonary circuit. At fifteen seconds the contrast

MEDIASTINAL PSEUDO-TUMOR—MATTES AND FAGIN



Figs. 1, 2, 3 and 4

medium was visualized in the left ventricle and aorta (Fig. 4); demonstrating the large left ventricle, the aneurysmal dilatation of the ascending aorta, and the tortuous descending aorta overlapping the enlarged left ventricle to produce the confusing oval shadow seen in the preliminary roentgenogram.

Thus, an enlarged left ventricle overlapping a tortuous or aneurysmal descending aorta can produce an oval density simulating a posterior mediastinal tumor. This can usually only be visualized in the left anterior oblique position. Cardiac aneurysms, on the other hand, are usually seen in the postero-anterior projection.

From the preface of Caffey's book¹ the following paragraph is appropriate: "Shadows are but dark and twisted phantoms beyond the substance; alone they are without meaning. He who would comprehend the roentgen shades needs always to know well the material substrate whence they spring—needs always to know well the human body through which the black light streams to reveal the innermost structure in shadowy images."

(Continued on Page 69)

Rectal Administration of Dicumarol in a Case of Mesenteric Venous Thrombosis

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AT PRESENT the anticoagulant Dicumarol represents one of the most effective weapons in the treatment of thromboembolic phenomena. Particularly in cases requiring prolonged anticoagulation do its low cost, sustained action, relative ease of control and facility of administration make it superior to heparin.

Clinically the only practicable route of administration is by mouth. The drug can be given intravenously as the disodium salt in an alkaline medium of pH 10 or slightly higher,⁴ but the instability of this solution and its alkalinity preclude its routine use.

Although the oral route of drug administration is preferred, clinical situations arise wherein an alternative route is either desirable or mandatory. Thus, in a patient requiring anticoagulant therapy in whom there is pernicious vomiting, continuous gastric aspiration or severe dysphagia, either heparin must be used exclusively or Dicumarol must be given otherwise than orally.

In 1943 Meyer and Spooner⁴ reported upon the rectal administration of Dicumarol. In only four out of thirty-four cases, using a dosage of from 5 mg./kg. to 10 mg./kg., was a satisfactory elevation in prothrombin time obtained. They concluded that dicumarol per rectum was only occasionally effective and that its routine use could therefore not be recommended.

The following is the report of a case of mesenteric venous thrombosis in which a postoperative complication necessitated prompt anticoagulant therapy. An effective increase in the prothrombin time was maintained by the rectal administration of Dicumarol:

W. S., a sixty-seven-year-old white mechanic, entered a small nearby hospital complaining of severe abdominal pain, which had come on suddenly in the periumbilical area twelve hours previously and had then radiated into

the right lower quadrant. There had been repeated vomiting since the onset of the pain.

Physical examination revealed an acutely ill patient who lay quietly in bed but whose face was distorted by pain. His temperature was 97.8° F., pulse 84 per minute and regular, respirations 20 per minute, blood pressure 130/80. The skin was ashen in color, cool and clammy. The abdomen was moderately distended and exhibited marked tenderness over the entire right side, with maximum tenderness over McBurney's point. There was no spasm or rigidity of the abdominal wall and no rebound tenderness; but palpation in all quadrants produced pain referred to the right lower quadrant. The remainder of the physical examination was within normal limits.

The admission blood count was as follows: hemoglobin 15.7 grams or 100 per cent; red blood cell count 5,430,000 per cu. mm.; white blood cell count 12,500 per cu. mm.; neutrophils 88, with 75 segmented and 13 nonsegmented forms; lymphocytes 12. No other preoperative laboratory work was performed.

Two hours after admission, with a preoperative diagnosis of acute appendicitis, a McBurney incision was made. Upon opening the abdomen approximately two quarts of serosanguinous fluid poured from the wound. Exploration revealed a gangrenous terminal ileum. This incision was closed and the abdomen was reopened via a midline suprapubic approach. Two-thirds of the terminal three feet of the ileum, with its attached mesentery, were completely gangrenous. The appendix was normal. The gangrenous bowel and its mesentery, with a generous margin of normal tissue, were resected and an end-to-end anastomosis performed. During the operation 1000 c.c. of 5 per cent glucose in normal saline were given intravenously. The patient left the operating room in good condition, with normal skin color and temperature, a regular pulse of 80 per minute and blood pressure 150/68. As soon as he had reacted, a Levine tube was passed and continuous Wangenstein drainage instituted. Daily administration of 300,000 units of procaine penicillin intramuscularly was initiated. Because of the risk of intra-abdominal bleeding, anticoagulant therapy was deferred in the immediate postoperative period.¹

On the first postoperative day the temperature rose to 100.4° F. The abdomen remained moderately distended and the patient hiccupped whenever the Levine tube became occluded. During the next five days the temperature oscillated between normal and 100.2° F., and abdominal distention persisted. Bowel sounds were inaudible, and nothing passed per rectum until the fourth postoperative day, when a large liquid brown stool and much flatus were produced.

On the fifth postoperative day the patient complained of soreness in the right calf. Examination revealed the entire right leg to be swollen, red and abnormally warm. There was three-plus edema of the foreleg, a strongly positive Homan's sign and marked calf tenderness. The temperature spiked to 100.6° F. The leg was elevated and in the presence of this fulminating thrombophlebitis it was decided to institute anticoagulant therapy.

Intravenous heparinization was started in intermittent

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MESENTERIC VENOUS THROMBOSIS—SELTZER

TABLE I

Post-Op Day	Time of Day	Heparin Mg. I-V (intermittent)	Daily Prothrombin Times in Seconds		Dicumarol Mg. per Rectum
			Control	Patient	
5	6:00 p.m.	100			
6	1:30 a.m.	50			
	6:00 a.m.	50			
	4:00 p.m.	100	14	15	400
7	12:30 a.m.	100			
	12:30 p.m.	100	14	17	800
8			14	30	100
9			14	32	
10			14	44	
11			14	26	100
12					
13			14	34	
14			Dicumarol Discont.		
15			14	15	
16					

doses, according to the method of Crafoord and Jorpes² The dosage schedule is shown in Table I. At the same time, oral Dicumarol administration was attempted by clamping the Levine tube for one hour after each dose, but vomiting and loss of the drug occurred each time shortly after clamping the tube, and this route was abandoned after two trials.

Accordingly on the sixth postoperative day, rectal administration of Dicumarol, in the form of cocoa butter suppositories, was commenced. Lacking a therapeutic guide the dosage was selected on a purely empirical basis, although it was believed that somewhat larger doses would be required than during oral therapy. The dosages used are recorded in Table I. Daily prothrombin times were determined by the one-stage method of Quick.³ Elevation of the patient's prothrombin time to a value twice that of the control was considered the optimum level.⁶ When the patient's prothrombin time exceeded thirty seconds Dicumarol was omitted for that day. No clotting times were obtained while heparin was being administered.

By the morning of the eighth postoperative day there was very little residual edema of the right leg, although there was still moderate tenderness in the calf. Three days later this tenderness had entirely disappeared, but it was deemed advisable to continue treatment for a few more days.

Continuous Wangenstein drainage was necessary until the thirteenth postoperative day because the patient became distended and hiccupped or vomited whenever the Levine tube was clamped. Fluid and electrolyte balance were maintained by daily intravenous infusions of 3000 c.c. of five per cent glucose in water or in normal saline. The sodium chloride requirements for the day were estimated following a Fantus test for urinary chlorides,³ performed on a morning specimen. Detailed analysis of the serum electrolytes was not obtainable in this small general hospital. Upon removal of the tube on the thirteenth day the patient retained all liquids and was rapidly advanced from clear liquids to high caloric liquids and then to a soft diet.

On the fourteenth postoperative day the patient first complained of nausea and abdominal pain. An hour later the incisional site opened spontaneously and drained a large amount of foul smelling sanguinopurulent material, a stained smear of which revealed numerous short, thick, Gram-negative rods. Dihydrostreptomycin and

sulfasuxidine were started, and the daily penicillin dosage was increased. After two days of profuse outpouring the drainage steadily decreased and the wound was entirely dry on the nineteenth day. The day prior to this the patient had the first semi-formed stool since his operation.

Following subsidence of the wound abscess, convalescence was rapid and uneventful except for moderate swelling of the right foot and ankle when the patient was up and about. He was discharged in good condition on the twenty-eighth postoperative day. It is now one year since his acute abdominal episode and he has regained and remains in his former excellent state of health.

The pathological report on the resected specimen was as follows: "Grossly this specimen consists of approximately two feet of gangrenous small bowel. At each end there is a small segment of essentially normal bowel structure. Microscopically, the wall of the bowel is enormously thickened by interstitial hemorrhage and edema. The tissue elements are becoming necrotic. The mesentery is likewise thickened and involved by extensive interstitial hemorrhage. This lesion has all the features of a mesenteric thrombosis except for the presence of a thrombus in the mesenteric vessels. This latter finding is not demonstrable. There is no evidence of neoplasm."

Summary

In this case of mesenteric thrombosis the patient survived despite a prolonged morbidity complicated by a severe thrombophlebitis and a large wound abscess. Immediate postoperative anticoagulant therapy was considered ill advised because of the risk of intra-abdominal hemorrhage. The development of thrombophlebitis in a lower extremity on the fifth postoperative day, however, necessitated its use in the face of an unremitting ileus which required continuous Wangenstein drainage. Cocoa butter suppositories of Dicumarol were therefore administered and an entirely satisfactory elevation of the prothrombin time was achieved.

Conclusions

A therapeutic effect on prothrombin activity can be achieved by Dicumarol given rectally. Administration of the drug by this route may be of advantage when circumstances prevent its use by mouth.

References

1. Allen, E. W.; Barker, N. W., and Waugh, J. M.: A preparation from spoiled sweet clover. *J.A.M.A.*, 120:1009, 1942.
2. Crafoord, C., and Jorpes, E.: Heparin as a prophylactic against thrombosis. *J.A.M.A.*, 116:2831, 1941.
3. Fantus, J. B.: Fluid postoperatively. *J.A.M.A.*, 107:14, 1936.
4. Meyer, O. O., and Spooner, M.: The rectal administration of dicumarol. *Proc. Soc. Exper. Biol. & Med.*, 54:88, 1943.
5. Quick, A. J.: *The Hemorrhagic Diseases and the Physiology of Hemostasis*. Pp. 25-34, 229-291, 312-316. Springfield: Charles C. Thomas Company, 1942.
6. Wright, I. S.; Marple, C. D., and Beck, D. F.: Report of the committee for evaluation of anticoagulants in the treatment of coronary thrombosis with myocardial infarction. *Am. Heart J.*, 36:801, 1948.

Dilaudid Suppositories for the Suppression of the Cough Reflex

With Review of Medication by Rectal Administration in Childhood Diseases

By K. Donelson, M.D.
Dearborn, Michigan

WHILE TREATING an upper respiratory infection probably of virus etiology, in a two-year-old girl (T.D.), a severe, nonproductive, constant cough was present with extensive hyperemia and edema of all the nasopharyngeal tissues. Otitis media, mild, was the only other positive sign, chest signs being entirely negative. Rectal temperature was 104°, pulse 144, respirations 40.

300,000 units of Crystalline Penicillin Procaine G in Oil with 2 per cent aluminum monostearate were administered intramuscularly. It was impossible to administer medication orally because the child had refused food and liquids for twenty-four hours, probably due to the pain and swelling. A gavage tube was not available. The inflammation was progressing rapidly, and after four hours it seemed that the trauma of the constant cough was the chief factor in the increased swelling and edema of the tonsils which was starting to cause a stridor in the breathing. It seemed imperative to depress the cough immediately, as the possibility of performing a tracheotomy seemed imminent.

Calls to several pharmacies for codeine or some other morphine derivative in suppository form, revealed that only Dilaudid, grains 1/24, was available. One-half of a suppository was inserted rectally, and within fifteen minutes not only had the cough subsided but also the child had ceased crying and had gone to sleep. Respirations were depressed to 15 per minute. After two hours the stridor had subsided considerably and instructions were left to continue the suppositories at the rate of one-half (Dilaudid 1/48 grains) if the cough recurred, providing the respirations were above 20 per minute. A second dose was required about seven hours after the initial dose.

Examination after twenty-four hours revealed dramatic change. The inflammatory reaction in the throat had undergone a remarkable improvement, no edema and only slight hyperemia remained, although the rectal temperature was still 101°, pulse 132, respirations 22. The mother reported that the child had taken fluid twice during the night and had eaten well during the day. It was believed that removal of the mechanical trauma of the cough was the predominant factor in this sudden improvement of the nasopharyngeal tissues.

Additional Therapeutic Trials

The above case responded so dramatically that Dilaudid suppositories were used in thirty-two

consecutive clinical cases as the sole adjunct to penicillin in cases of upper respiratory infections, with nonproductive cough but negative chest findings. Dilaudid was also used to suppress pain in several cases of severe cervical adenitis and otitis media of undetermined etiologies. The age group of the above-mentioned cases ranged from six months to four years. There was no difficulty with the premature expulsion of the drug before absorption.

The results seem to me to be so spectacular and the gratitude of the mothers of these children so great that this report is offered to the profession in its purely empirical form with the hope that scientific research and clinical trial will be accelerated, not only with Dilaudid but all medications that can be administered rectally in childhood diseases. A discussion of this route of medication follows.

Rectal Mode of Administration of Drugs in General

While on the West Coast in 1949, it was observed that acetylsalicylic acid and barbiturate suppositories were used very freely by several pediatricians. Also suppositories of these drugs were available at the majority of the pharmacies without a special order. Since returning to the Middle West, it has been difficult to find pharmacies stocking these suppositories or any suppositories containing dosages small enough for administration to children. This would seem to be an indication that the rectal mode of administration has very limited use by general practitioners treating children in this area.

Attention is called to some of the advantages and disadvantages of the rectal mode of administration of drugs.

Advantages.—

1. Ease of administration to children, particularly by mothers.
2. As an alternate method of administration where there is difficulty in swallowing due to swelling or pain.
3. When the predominating symptoms are nausea or vomiting.
4. Elimination of the difficulty in attempting to force oral medication on children.
5. Elimination of the fear caused by the pain of the hypodermic injection.

Disadvantages.—

1. Expulsion of the medicine before complete absorption.
2. Most suppositories require refrigeration.

(Continued on Page 64)

A Rational Approach to Benign Prostatic Hypertrophy

By William J. Butler, M.D.
St. Joseph, Michigan

THE MORBID state resulting from benign prostatic hypertrophy is not uncommon in the male population after the fourth decade. Less frequently the case of complete urinary retention is brought to the physician's attention and obviously requires surgical consideration. However, the average physician encounters a much larger group of men who have symptoms of obstruction to the outflow of urine, decrease in size and force of the stream, frequency, and nocturia. Often the history is not forthcoming but requires careful questioning, observation of the voided stream, and rectal palpation of the prostate. Indeed there is a small group of patients who have no urinary complaints at all (although careful questioning usually discloses urinary symptoms) but have uremia from chronic urinary retention. Furthermore, there is an erroneous belief by many physicians that a grossly enlarged prostate is necessary to cause obstruction. Actually, a small hypertrophied prostate may cause complete urinary retention as effectively as the large gland, and the amazing fact remains that an enormous hypertrophy may occur before complete obstruction intervenes. Since the urethra is about 1 cm. in diameter, it requires but little stretch of the imagination to see how easily it is obstructed by projection of the lateral lobes 0.5 cm. into the lumen. Almost half of all prostatectomies in one large hospital were performed upon glands of normal size and weight. Many of these patients were in complete retention.

Endoscopic observation of the prostatic urethra of men from the fifth decade onward will disclose some degree of intraluminal projection of the prostate in the vast majority. In some there is observed complete occlusion, and yet these people may be emptying their bladders. On the other hand, men are observed in complete retention where the hypertrophied lobes are not in total apposition. The answer to this situation is found in the bladder, a smooth muscle viscus that is too often ignored in the concept of prostatic hypertrophy. It is this bladder muscle that generates the hydrostatic pressure sufficient to separate the soft

and yielding prostatic lobes which fill the lumen of the prostatic urethra. Indeed, it is this yielding, expansive quality of the glandular hypertrophy of the prostate that allows the disease to proceed for a prolonged period.

The bladder musculature reacts to obstruction of the urethra by hypertrophy and increased work. The corrective capacity on the part of this muscle is remarkable, and when the compensation is complete, the patient experiences few or no symptoms that might draw his attention to the urinary function. The bladder hypertrophy progresses as the lumen of the urethra decreases, and a correct balance is often maintained for many years. The force of the stream is good during this phase, but the caliber is usually diminished when observed by the physician. The symptom of frequency very often develops during this stage but may be hardly noticeable at first. Ultimately, the patient observes that he cannot sleep the entire night without rising one or more times to void. This is associated with increased irritability and a decreased capacity of the bladder, with a definite desire to void when the bladder is distended with a smaller quantity of urine than he previously experienced. This smaller capacity is possibly a result of the increased reflex activity of the hypertrophied musculature. The bladder is now grossly trabeculated by hypertrophied ridges of muscle, and often develops cellules and diverticula. The latter are outpouchings, or "blow-outs," of the bladder mucosa through the interlacing strands of muscle, and occur in certain people but not in others. Variation in the configuration of the muscle bundles with scattered weak points is a possible predisposing factor of their development. When this occurs, the patient starts to carry a residual urine equal to the capacity of the diverticula, because part of the urine is voided through the urethra and part into the diverticula, which have no musculature in their walls. In a similar manner, some patients develop reflux up the ureters, which become dilated and act in the manner of diverticula.

Case 1.—H. B., a man aged forty-eight, had recurrent episodes of frequency of urination for two years. He had prostatic massages with temporary relief. During the present attack he had nocturia two to four times. The size and force of the stream has been reduced for the past two years. On examination the prostate was small and benign, the urine was normal, and there was no residual urine upon catheterization. Cystoscopic

BENIGN PROSTATIC HYPERTROPHY—BUTLER

examination disclosed gross trabeculation of the bladder with left lateral lobe and median lobe obstructing prostatic hypertrophy. The nonprotein nitrogen was normal. He responded well upon medical management and the nocturia was reduced to once per night.

The stage of decompensation of the bladder muscle is heralded by the presence of residual urine after the patient has voided. This may be intermittent at first. Typically, if he allows his bladder to become distended, he notes that within a few minutes after voiding he again has the desire and is able to void a further amount. The fatigued muscle in this case empties partly, rapidly regains strength, and on the second contraction empties the bladder. Progression of the fatigue state results in an ever-present residual urine. The muscular mass is no longer capable of a sustained emptying contraction, and the voided stream stops and starts, dribbles, regains force and ends in a prolonged dribble. The unfortunate individual, enslaved to the perversity of his urination, repeatedly returns to the toilet in the vain pursuit of an empty bladder. He may develop incontinence, and finally either "overflow" or complete urinary retention. The bladder muscle has now failed and is incapable of a sustained contraction. Even then the intra-abdominal pressure is sometimes sufficient to expel a small dribble of urine by "overflow." Similarly, some patients develop uremia with bilateral hydronephrosis and hydroureters with a large residual urine while still able to void small amounts without apparent discomfort. This is known as silent prostatism, and every doctor should be on his guard for this serious situation. Permanent renal damage may occur, increasing the operative risk tremendously and in some instances preventing a surgical attack upon the prostate. Finally, in cases of long standing, the decompensated bladder may undergo irreversible atrophy, so that it may never again be capable of emptying in spite of complete rest on prolonged drainage, either by suprapubic or by urethral catheter.

Case 2.—J. W., a man aged sixty-seven, for the past eighteen months had noted progressive increase of fatigue, 15 pounds weight loss, nausea and dyspepsia upon arising in the morning, and constipation. Careful questioning elicited frequent nocturnal urinary incontinence. He was unable to continue his job as a railway clerk. Treatment during the year has been a gastric ulcer diet and liver "shots" for severe anemia. He voids without discomfort and has no symptoms drawing his attention to the bladder.

Examination demonstrated a thin, chronically ill, anemic man in no distress. A large soft cystic mass fills the lower abdomen. The prostate is enlarged and benign to palpation. Urinalysis: specific gravity, 1012; albumin, 2; sugar, 0; white cells, 1; red cells, 3. Blood non-protein nitrogen, 217 mg. per cent. Emergency suprapubic cystostomy was performed and 1200 c.c. of urine obtained. The patient is now on permanent cystostomy drainage because the nonprotein nitrogen remains at 92 mg. per cent, although he has improved remarkably six months after operation.

Patients with urethral obstruction are prone to develop bladder calculi, urinary infection, epididymitis, and pyelonephritis at any stage of the disease. Any of these complications may be the presenting problem and the underlying cause should be suspected in any man over fifty years of age. The rate of progress of this disease complex is influenced on one hand by the development of the obstructing tissue and on the other hand by the capacity of that individual's bladder to respond to the increased demands placed upon it. The latter response may be influenced by the general state of nutrition and concurrent constitutional diseases. Benign hypertrophy begins in the fourth decade, although serious clinical symptoms may not become apparent until the sixth or seventh decade. The average age at which these people come to operation is seventy years. Acute retention may be precipitated at any stage of the disease by inflammation or edema of the prostate.

The diagnosis of benign hypertrophy of the prostate is made by rectal palpation of the gland, and, if necessary, confirmed by cystoscopy. It is not necessary that the gland be enormously enlarged, for most obstructions result from glands weighing 20 to 30 gm. It must be differentiated from carcinoma of the prostate, for which digital palpation is most important, with secondary assistance from the blood phosphatases and bone x-rays. Tumors of the bladder, bladder calculi, and renal lesions must also be recognized, for which intravenous pyelography is of great aid. When the diagnosis of a benign prostatic hypertrophy is made, the immediate decision about the future management depends upon the stage of the disease that is present.

The advanced stage is apparent by one or all of the following: (1) elevation of the blood nitrogen, (2) marked decrease in the size and force of the stream, (3) a residual urine of over two ounces, (4) complete urinary retention, (5) or where the excretory pyelogram shows gross tra-

beculation of the bladder, diverticula, or ureteral dilatation. In these patients serious consideration for surgical correction should immediately be undertaken. When infection is present in the urine a course of sulfonamide, 0.5 gm. four times daily, for a week will be adequate in most cases. If the infection continues the physician should be on his guard for high residual urine, calculi, or complicating urinary lesions. Furthermore, detailed urinary investigation is then indicated. Similarly, the presence of hematuria, either gross or microscopic, should be thoroughly investigated by cystoscopy and pyelography, as tumors also occur most commonly in this age group. Gross repeated hemorrhage from an hypertrophied prostate should be given definite consideration for surgical correction by prostatectomy.

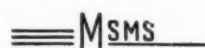
The early stage is indicated by nocturia less than three times nightly, no residual urine, normal blood nitrogen level, and only moderate decrease in the size and force of the urinary stream. If an excretory pyelogram shows no evidence of renal or bladder complications, this patient may be handled by a medical regime and checked at half-year to yearly intervals to evaluate the progress of his disease. The patient should be instructed to drink a glass of fluid every hour from breakfast until 2:00 p.m. After this, he should drink his usual amount, and after 6:00 p.m. he must limit fluids. In this manner the total twenty-four-hour fluid intake is increased and yet there is less urine produced during the hours of sleep, because the greater part has been eliminated by 10:00 p.m. A nightly Sitz bath will aid in decreasing bladder irritability. Tincture of hyocyanus, 1 c.c., before meals, will also decrease bladder irritability. A balanced diet, high vitamin intake, and the correction of associated systemic diseases are essential to the well-being of the patient. Alcoholic beverages, if so desired, may be taken in moderation.

Many patients will obtain marked symptomatic relief upon such a program as above outlined. As time passes the patient may enter the more advanced stages of the disease and will then require surgical intervention.

Summary

It has been emphasized that symptoms from benign prostatic hypertrophy are common from the fifth decade onward. It is the physician's re-

sponsibility to recognize the disease, evaluate the patient's status, and to institute the proper therapy. The urinary function is an expression of the compensation or decompensation of the smooth musculature of the bladder. Urinary infection, pyelonephritis, epididymitis, prostatitis, and calculi may complicate the picture. Furthermore, hemorrhage, either gross or microscopic, and resistant infections require thorough urologic investigation by cystoscopy and retrograde pyelograms. Less advanced cases may be managed by a regime of careful observation and medical therapy.



DILAUDID SUPPOSITORIES FOR THE SUPPRESSION OF THE COUGH REFLEX

(Continued from Page 61)

I firmly believe that infants and children should receive the same consideration as to the relief of pain as adults, especially since there is less danger of narcotic addiction than in adults.

Conclusion

1. One case history is presented in which the inflammatory symptoms of the nasopharyngeal tissues subsided dramatically following suppression of the cough reflex with Dilaudid suppositories as an adjunct to routine treatment of an acute upper respiratory infection.

2. It is only suggested that the mechanical trauma of coughing may be a factor in aggravation of the inflammation of the nasopharynx in the upper respiratory infections with nonproductive cough.

3. While empirically it is my impression that Dilaudid suppositories administered rectally are much more effective and less toxic than codeine administered orally, as far as suppression of the cough reflex and relief of pain are concerned, no scientific data has been gathered nor are any scientific claims made.

4. A plea is being made to the medical profession for a thorough research and clinical investigation of the rectal mode of administration for all drugs and medicine used in the treatment of diseases of infants and childhood.

24628 Penn Ave.
Dearborn, Mich.

Detroit Physiological Society

Meeting of October 19, 1950

Connective Tissue Alterations In Degenerative Disease

C. H. ALTSHULER, M.D.
Wayne County General Hospital

The reported study was undertaken to determine the conditions under which acid mucopolysaccharides, such as hyaluronic acid and chondroitin sulfuric acid, are formed. Using histochemical staining techniques, it was observed that these carbohydrate polymers are frequently produced in the early stages of serous inflammation (Rössle).

Since serous inflammation has been studied extensively, much information is available concerning the conditions under which the acid mucopolysaccharides may form. Ordinarily, serous inflammation is found to be associated with increased capillary and cell membrane permeability and decreased tissue permeation. Retention of sodium, chloride and water and loss of tissue potassium and phosphate have been reported. Increased glycolysis (carbohydrate breakdown with formation of lactic acid) also occurs. The chronological order and significance of each of the individual changes in this process is not known.

Serous inflammation has been reported to be of significance in rheumatic lesions, vascular alterations associated with malignant hypertension, cardiac changes in beriberi, myxedema and other conditions. It is also believed to be involved in certain degenerative diseases of the connective tissue such as sclerosis, hyalinization, and fibrinoid formation. The latter degenerative structures give a positive reaction for polysaccharide aldehyde (periodic acidleukofuchsin) and have a temporal, spatial and configurational relationship to the acid mucopolysaccharides. Therefore, it is believed that the acid carbohydrate polymers participate in the reactions resulting in these degenerative formations. The exact manner is not known.

Since many current investigations concern themselves with aspects of serous inflammation, a more detailed evaluation and appreciation of the proc-

ess is desirable. Examples of such studies are those which relate to the "general adaptation syndrome" of Selye, the mechanism of action of ACTH, the hyaluronic acid hyaluronidase system in the rheumatic diseases, and anti-reticular cytotoxic serum.

The Effect of Portacaval Venous Shunt Upon Bromsulphalein Retention

D. E. PRESRAW, M.D., ALFRED LARGE, M.D., and
ARTHUR F. JOHNSON, PH.D.

*Department of Surgery, Wayne University College
of Medicine*

An experimental study of the effect of diversion of the portal blood flow upon liver function in the dog is reported. Animals were prepared with both partial and complete shunts of portal blood away from the liver. Bromsulphalein retention was used as an index of liver function in these animals. Studies of the resistance of the liver in shunted and control animals to carbon tetrachloride poisoning also are reported. It was found that the animals with complete portacaval shunt (Eck Fistula) retained more bromsulphalein than did either the controls or those animals with partial shunts, and also that the Eck fistula animals tolerated carbon tetrachloride poisoning less well than did the other two groups.

It is suggested that portacaval venous anastomoses in the human be performed so as to only partially shunt the portal blood away from the liver.

Microtechnique: Essentials of the Paraffin Method (Full color-sound film; running time 26 min.)

FREDERICK A. WATERMAN, PH.D.
Department of Biology, Wayne University

This film shows the complete process of making microscopic preparations by the paraffin method. It covers every step from removing the tissues from the anesthetized animal to final labeling

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The investigative work was carried out in collaboration with Dr. D. M. Angivine, Chairman of the Department of Pathology, University of Wisconsin.

Shadows

We have asked many of our confrères what they most desired in postgraduate training. Most of you have claimed special interests and wanted to further perfect them. That is why the specialist is so eager to see that his specialty is adequately covered in the Postgraduate Institute in March. The Academy of General Practice has been most helpful in developing a portion of the program which would appear to be more closely related to their memberships' desires. We have pioneered and have been told our results were good. The Michigan plan of postgraduate training has been widely emulated. It has been called one of the best in the world.

A more recent innovation has been the advent of postgraduate training departments in the larger hospitals. These serve the dual purpose of correlating the training of the resident staff, as well as working out a supplementary course of training for visiting doctors. Probably one of the most important results of this type of training has been the splendid opportunity offered for research. Why, then, are we not satisfied with all this?

The answer is simple. There are claims made that we are developing only highly specialized doctors of medicine who are unable to perform many of the little but important services which patients have a right to expect of their doctors. The recent graduate is forced, because of his Board membership, to do only those things which can be done in a well-equipped hospital. He cannot relieve his older confrère of part of the exhausting drudgery connected with making home calls. This often leads to dissatisfaction when many doctors are contacted and services are unobtainable. The public relations growing out of this phase of medical care has many repercussions. In fact, many patients have been denied the excellent care which should have been available and have resorted to those sub-standard cults practicing the healing arts. We predict that, if this tendency to treat patients only within the narrow confines of a specialty continues, soon all patients will be hospitalized for all care. We know this to be unnecessary and believe it has already progressed much farther than it should. We believe that the cost of medical and hospital care insurance programs will become prohibi-

tive and aggravate further the demand for even more expensive and less efficient socialized medicine.

Why then should we cast the shadows of socialism over our postgraduate program? For this reason only we should be willing to face any inadequacy and broaden our present excellent facilities to cover them.

For those recent graduates who have passed their Board examinations, we would recommend a four-year period of acclimation. During this time they would be free to perform any service requested of them for which they are qualified. An even better plan would be a working arrangement with a busy general practitioner. Another approach would be to make specialty training, in a teaching hospital, available after the young doctor had completed one or two years of hospital training and four years of general practice.

Many times during the past five years we have heard the complaint that doctors, who have been in general practice ten, twenty or thirty years, find it impossible to complete a specialty training. There is no place for them in the teaching hospital. Many times the general practitioner has spent four or five years, before entering general practice, in a hospital not approved for teaching purposes. At the present time there is no provision for this practitioner to review his specialty techniques and basic sciences under supervision and then present himself for examination. We believe a course with qualifying credits could be made available. A few enterprising members of the medical profession have been able to work out such a program on their own initiative, but all encountered tremendous difficulties.

This latter phase of postgraduate training was discussed a few days ago with one of our Past Presidents, E. F. Sladek, M.D., of Traverse City. He had a most encouraging story to tell, and we shall hope to hear more of his plan soon.

I wish to repeat, our present plan of postgraduate medical education is excellent. Let us then make any necessary addition and remove some of the shadows being cast on medical care.

Clifford M. D.

President, Michigan State Medical Society

President's



Message

Editorial

MICHIGAN MEDICAL SERVICE OVER 2,000,000 SUBSCRIBERS

MICHIGAN MEDICAL SERVICE has continually demonstrated its grand service to the people of the State of Michigan and to the members of the Michigan State Medical Society who had the foresight to pioneer in the formation of this great public service corporation. Our members are justifiably proud of the accomplishment of our voluntary health service program and of the great strides which it is making in benefits to our subscribers and members. This is an enterprise which belongs particularly to us. It is our bulwark against socialized medicine. It is our means of distributing our services to our people, and it is especially our means for aiding our people in paying for services which many thousands of them would be unable to afford were it not for a method of prepayment.

As of November 23, 1950, we had 2,006,513 persons protected by Michigan Medical Service. Michigan was the first of the Blue Shield Plans to reach the million mark. At the million and a half mark, we were surpassed by a few thousand by the United Medical Service of New York, but when it came to the two million mark, Michigan is again the first medical service group to insure two million people. This is one-third of the population of our state. We have reason to be proud, but we are not entirely satisfied. Ultimately, we have reason to feel, our own public service plan will be a complete success.

As of October 1, 1950, Michigan Medical Service had paid for medical and surgical services to its certificate holders \$47,624,494.50 and for the veterans plan \$4,571,490.58, making a grand total paid out for professional services and benefits to our subscribers \$52,195,985.08.

TOO LARGE?

ONE OF THE large Michigan drug companies has notified Blue Cross that it is withdrawing, not because it does not believe in the principle of private prepayment medical and health care, but to encourage the formation of other sources of that coverage. It believes these plans

should be small with many of them, so the services could be easily obtainable.

Prepaid medical and hospital service, naturally and logically, must be administered by a company large enough to guarantee an equitable and safe insurance risk. We have talked with physicians and executives of medical prepaid non-profit plans throughout the country, and they envy Michigan and other states where the plans are large enough to be secure and stable.

We asked the detail man from this drug company what would happen if his company were thought to be too big, and was divided into a half dozen smaller companies. He threw up his hands in horror, and said there would be no . . . company.

One very strong point to consider in medical and hospital service plans is that the medically sponsored companies fix fees and payments by consultation with the doctors and hospitals and may consider them full payment under the wage ceiling. The "for profit" insurance companies never consult the doctors in setting up their schedules of fees, and in fact are not offering anything else than an indemnity. The Insurance Company and the insured hope the doctors and hospitals will accept their payments as full payment. There is no such obligation unless the benefits have been negotiated between the doctor, the hospital and the patient.

It should be noted that one high official of this company retains Blue Cross and Blue Shield for his own family group.

MEDICAL EDUCATION

ALBERT Q. MAISEL has again broken into print in an article very critical of the medical profession. *Collier's* magazine for December 16, contains over four pages about "Our Alarming Doctor Shortage," with a corner block signed by the editor saying, "We hope that the AMA leaders will withdraw their opposition." This is one of many articles which have appeared, apparently instigated by the Federal Security Administrator in his effort to gain control of the practice of medicine.

The American Medical Association has acted to lay that canard at rest. At the interim session

EDITORIAL

at Cleveland, December 6, 1950, it appropriated a half million dollars for the aid and support of medical schools in need of additional financing.

The profession has never failed to support medical education. On the contrary, it has been instrumental in raising the standards, in attempting to guarantee that students will have the very best of instruction and opportunity. It has encouraged excellence of training as well as increased numbers, because it knew only too well the need of the very best skill and training at the bedside and at the operating table.

Michigan has not been behind. The Michigan State Medical Society has repeatedly fostered additional financing for our medical schools especially by appeals to the legislature and by sponsoring additional facilities for increased training.

WE MUST NOT FORGET

MANY OF OUR members and some of our administrative workers felt great relief at the result of the election held in November. We looked with pride upon the thinning numbers of our most sinister Senators and felt that the bureaucrats in Washington who are determined to continue this socializing process of the American people would take a hint and become less active. That was not to be.

Late in October, the CIO "Committee for Public Health" published an advertisement in many papers throughout the country containing part truths, misleading statements, and some downright misstatements. This advertisement featured a letter supposed to have been written by a mother to her doctor and was timed to catch many votes just before election. On another page, we are publishing the radio reply of L. Fernald Foster, M.D., Secretary of the Michigan State Medical Society. If you have not done so, you are urged to read this masterpiece, on page 1442 of *THE JOURNAL* for December, 1950.

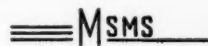
A large sheet of paper about the size of a newspaper page, printed upon one side as if it were a copy of a page advertisement was received by the Editor at his R.F.D. address. We do not know the extent of distribution but it came from the A.F. of L. national headquarters in Washington and is signed by William Green, President, and George Meany, Secretary. It contains practically the same slanted information as the advertisement of the CIO. It was also featured in one corner by a disrespectful letter which the recipient is sup-

posed to sign and send to his doctor. The advertisement asked for contributions for the Committee for the Nation's Health, the group of left wingers who are continuing the campaign for socialized medicine and who have been certified as Communist front.

(Incidentally, the A.F. of L. is not unanimous. President W. L. Hutcheson of the Carpenters and Joiners Brotherhood addressed the AMA at Cleveland, strongly in favor of Medicine's side of this controversy.)

President Truman, last November, restated his policy of determination to repeal the Taft-Hartley Law, to further socialize Agriculture, Education, and especially his program on "National Health Insurance," his euphemistic term for "socialized medicine."

Now, above all times, we must not relent in our efforts to thwart the socializers. A newspaper publisher friend of ours, after the election, asked whether we were satisfied and commented that we might rest now for two years. Asked if he really believed this, he told the story which used to be prevalent on the Kansas plains, "The only safe rattle snake is the one hung on the fence."



MEDIASTINAL PSEUDO-TUMOR

(Continued from Page 58)

Summary

A case is reported wherein the overlapping of an enlarged left ventricle and a tortuous descending aorta simulated a posterior mediastinal tumor in the left anterior oblique view. Angiocardiography served to define the components of this pseudo-tumor.

Reference

1. Caffey, J.: *Pediatric X-Ray Diagnosis*. Chicago: Yearbook Publishers, 1945.

WHAT OUR READERS SAY

"If it weren't for those of you, particularly Corbus and yourself down through the years, medical economics would have taken an awful beating."—W. A. HYLAND.

"... proud of the work you have done and accomplished, especially with the state society and *JOURNAL*. It has been a tremendous job with perhaps very little thanks, but nevertheless we all appreciate the good work you have been doing."—EDWARD M. VARDON.

"I want to pay my respects to you for the editorial skill shown. . . . Have always enjoyed editorial work myself."—F. J. SLADEN.

Fifth Annual Michigan Postgraduate Clinical Institute

BOOK-CADILLAC HOTEL, DETROIT

MARCH 14, 15, 16, 1951

BURTON R. CORBUS, M.D., Grand Rapids, *General Chairman*

Information

- **HEADQUARTERS.**—Book-Cadillac Hotel; Assemblies, Exhibits and Press Room on Fourth Floor; Luncheons in English Room on Mezzanine Floor.
- **REGISTRATION.**—Tuesday noon through Saturday noon, March 13-17, Book-Cadillac Hotel.
- **ADMISSION BY BADGE ONLY** to all meetings and to the exhibits. Present your MSMS, State or Canadian Medical Association membership card to expedite registration.
NO REGISTRATION FEE FOR MSMS OR OTHER STATE MEDICAL SOCIETY MEMBERS, OR FOR CANADIAN MEDICAL ASSOCIATION MEMBERS.
- **ADVANCE REGISTRATION WILL SAVE YOUR TIME.**—Preconvention registration is arranged for Tuesday, March 13, 1:00 p.m. to 4:30 p.m. Registration will resume Wednesday, March 14 at 7:30 a.m. Avoid waiting in line by registering Tuesday afternoon or early Wednesday morning.
- **SUBSCRIPTION LUNCHEONS.**—Wednesday, Thursday, Friday, Saturday, March 14-15-16-17, English Room, Book-Cadillac Hotel, 12:15 noon to 2:00 p.m. with a thirty-minute scientific address following each luncheon. See Program, pages 72, 74, 75.
- **WEDNESDAY NIGHT — ENTERTAINMENT CABARET STYLE:**
8:30 p.m. Don Large and his five Grenadiers; fine choral voices.
9:00 p.m. to 1:00 a.m. Battle of Music—the Old vs the New! This battle will feature The Old Timers playing for square dances and quadrilles, and Reg Thornton and his orchestra, Detroit's outstanding band playing sweet numbers and South American tempos.
- **TELEPHONE SERVICE.**—Local and long distance telephone service will be available in the Book-Cadillac Hotel, fourth floor. In case of emergency, physicians will be paged from the meetings by announcement on the screen. Call the Book-Cadillac Hotel, Detroit, Woodward 1-8000, and ask for the Michigan Postgraduate Clinical Institute extensions on the fourth floor.
- **CHECKROOM** is available in the Book-Cadillac Hotel, fourth floor.
- **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Committee on Arrangements. This request is made in order to avoid confusion and disappointment on the part of members of the audience.
- **PAPERS WILL BEGIN AND END ON TIME.**—Nothing makes a scientific meeting more attractive than by-the-clock promptness and regularity; therefore, all meetings, luncheons, and clinical conferences

will open exactly on time, all speakers will be required to begin their talks exactly on time and to close exactly on time, in accordance with the schedule in the Program. All who attend the Institute and the Heart Day are respectfully requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly, in order not to miss that portion of the program of greatest interest.

- **TECHNICAL EXHIBITS.**—74 interesting and instructive displays—will open daily at 8:30 a.m. and close at 5:30 p.m., except on Friday, when the exhibit breaks up at 3:30 p.m. No exhibit on Saturday. Frequent intermissions to view the exhibits have been arranged daily before, during and after the assemblies and luncheons.
- **REGISTER AT EVERY BOOTH.**—There is something of interest or education in the large exhibit of technical displays. Stop and show your appreciation of the exhibitors' support in helping to make successful the 1951 Michigan Postgraduate Clinical Institute.
- **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Michigan Postgraduate Clinical Institute and the Heart Day.
- **HEART DAY.**—Saturday, March 17—See program, Page 76.

NO REGISTRATION FEE

- **SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN POSTGRADUATE CLINICAL INSTITUTE.**
- **PARKING.**—Do not park on Detroit's streets. Rates for inside parking, supplied us by three of the several garages written for this information, are as follows:
DAC Garage, 1754 Randolph St., opposite DAC, hourly rate 30c for first hour, 10c each additional hour; daily rate, \$1.50; three-day rate, \$4.50; weekly rate, \$9.00. In and out privileges on the daily, three-day rate and weekly rate. Delivery to hotel.
Grand Circus Garage, Adams Ave. at Randolph, 5 hours, 80c; 10 hours, \$1.05; 1 day (24 hours), \$1.50; 1 week, \$9.00 (includes in and out service any time, day or night). Delivery to hotel.
Book Tower Garage, Inc.—Daily rates 50c first hour, 10c each additional hour; minimum \$2.00 for 24 hours; weekly rate \$10.00. Delivery to hotel.
- **INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE** will be found at the Michigan Postgraduate Clinical Institute. All subjects on the Institute Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

PROGRAM

- **SCROLL TO LUNETTE I. POWERS, M.D., MUS-KEGON.**—Chosen by the Michigan State Medical Society as "Michigan's Foremost Family Physician of 1950," Dr. Powers will be honored on Wednesday, March 14 at the evening meeting when a Scroll emblematic of her new title will be presented to her.

● MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS.

To date, arrangements have been made by the following groups to meet in Detroit coincident with the Michigan Postgraduate Clinical Institute:

1. The Michigan Proctologic Society will meet on Wednesday, March 14, Pan American Room, Book-Cadillac Hotel; preprandial hour at 6:30 p.m. and dinner at 7:00 p.m.

2. The Michigan Regional Committee on Fractures and Other Traumas of the American College of Surgeons will meet on Thursday, March 15, Suite 500 Book-Cadillac Hotel; luncheon from 12:00 noon to 2:00 p.m., followed by a symposium from 2:00 to 5:00 p.m.

3. The Michigan Branch of the American Academy of Pediatrics and the Detroit Pediatric Society are joint sponsors of a dinner meeting to be held in Founders Room of the Book-Cadillac Hotel, Wednesday, March 14, 1951. Cocktail hour at 6:30 p.m.; dinner at 7:30 p.m.

Harry Shwachman, M.D., Director of Clinical Laboratories at Children's Medical Center, Boston, and

Associate in Pediatrics, Harvard Medical School, will speak on "The Coeliac Syndrome."

All doctors attending the Institute are cordially invited to attend the subscription dinner and to hear Dr. Shwachman's interesting talk. For dinner reservation write Wilfrid S. Nolting, M.D., 16840 E. Warren, Detroit 24.

4. The Michigan Society of Neurology and Psychiatry will meet on Thursday, March 15, David Whitney House; dinner at 6:30 p.m. followed by a scientific meeting at 8:00 p.m.

5. The Wayne University College of Medicine Alumni Association will meet for dinner at 6:30 p.m., English Room, Book-Cadillac Hotel, on Wednesday, March 14, 1951.

6. The Michigan Academy of General Practice will hold a meeting on Wednesday, March 14, 1951, 5:00 to 6:30 p.m., Reception Room, Book-Cadillac Hotel.

7. The Michigan Arthritis and Rheumatism Foundation will have a dinner and business meeting on Thursday, March 15, 1951, beginning at 6:30 p.m., Suite 500, Book-Cadillac Hotel.

8. The Michigan Pathological Society will hold a luncheon coincident with the Michigan Postgraduate Clinical Institute. Date, time and place of the luncheon will be announced at a later date.

9. The Woman's Auxiliary to the Michigan State Medical Society will hold a Board meeting on Wednesday, March 14, beginning at 10:00 a.m., Reception Room, Book-Cadillac Hotel.

PROGRAM

Wednesday, March 14, 1951

A.M.

7:30 REGISTRATION—Fifth Floor

8:30 EXHIBITS OPEN—Fourth Floor

FIRST ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

DAVID I. SUGAR, M.D., Detroit, *Chairman*

8:50 Welcome

C. E. UMPHREY, M.D., Detroit

President, Michigan State Medical Society

W. W. BABCOCK, M.D., Detroit

President, Wayne County Medical Society

9:00 "Prematurity: (a) Prevention, and (b) Management of Delivery"

GEORGE KAMPERMAN, M.D., Detroit

9:20 "Management of the Premature Infant"

CLEMENT A. SMITH, M.D., Boston, Massachusetts

Director of Research on the Newborn, Boston Lying-In Hospital; Associate Professor of Pediatrics, Boston Lying-In Hospital, Harvard Medical School; Chief, Infants' Division of Children's Hospital

9:40 "Surgical Lesions in the Upper Abdomen in the Newborn and Infant"

CLIFFORD D. BENSON, M.D., Detroit

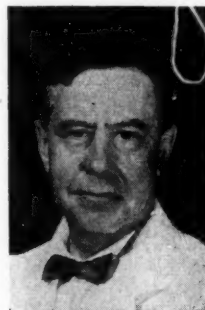
Assistant Professor of Clinical Surgery at Wayne University College of Medicine

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "Pancreatitis Clinical Manifestations and Treatment"

NOYES L. AVERY, JR., M.D., Grand Rapids

Consultant Staff Blodgett Memorial Hospital, Grand Rapids; F.A.C.P. Visiting Staff, St. Mary's and Butterworth Hospitals, Grand Rapids



C. A. SMITH, M.D.



N. L. AVERY, M.D.



G. KAMPERMAN, M.D.



C. D. BENSON, M.D.



A. G. GOETZ, M.D.



J. M. SHELDON, M.D.



G. N. RAINES, M.D.



D. A. BOYD, JR., M.D.



I. F. DUFF, M.D.



J. M. ROBB, M.D.

PROGRAM

- 11:20 "Operative Treatment of Fractures of the Os Calcis"
ANGUS G. GOETZ, M.D., Detroit

Associate Professor Department of Clinical Orthopedic Surgery and Acting Head of Department Orthopedic Surgery, Wayne University College of Medicine; Chief of Division of Orthopedic Surgery, Harper Hospital

- 11:40 "Antihistaminics"

JOHN M. SHELDON, M.D., Ann Arbor

Professor of Internal Medicine, University of Michigan Medical School

M

- 12:00 End of First Assembly

P.M.

- 12:15 LUNCHEON, English Room, Book-Cadillac Hotel

RAYMOND W. WAGGONER, M.D., Ann Arbor, *Chairman*

- 1:15 "Somatic Manifestations of Depression"

CAPTAIN GEORGE N. RAINES, M.C., U.S.N., Washington, D. C.

Head, Neuropsychiatric Branch, Bureau of Medicine and Surgery, Navy Department; Professor of Psychiatry and Director of the Department of Psychiatry, Georgetown University Medical Center; Director of American Board of Psychiatry and Neurology.

SECOND ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

ALBERT E. HEUSTIS, M.D., Lansing, *Chairman*

P.M.

- 2:00 "The Psychological Language of the Organs"

DAVID A. BOYD, JR., M.D., Rochester, Minnesota

Consultant in Psychiatry and Professor of Psychiatry, University of Minnesota Graduate School, Mayo Foundation, Rochester, Minnesota

- 2:20 "Administration of Anticoagulant Drugs"

IVAN F. DUFF, M.D., Ann Arbor

Assistant Professor of Internal Medicine, University of Michigan Medical School

- 2:40 "Cysts and Fistulae of the Face, Mouth and Neck"

J. MILTON ROBB, M.D., Detroit

Professor of Otolaryngology, Wayne University College of Medicine; Chairman of Section on Laryngology, Otology and Rhinology of the American Medical Association and President-Elect of the American Academy of Ophthalmology and Otolaryngology

- 3:00 INTERMISSION TO VIEW EXHIBITS

- 4:00 "The Diagnosis and Treatment of Chronic Small Intestinal Disease"

EVERETT D. KIEFER, M.D., Boston, Massachusetts

- 4:20 CLINICAL X-RAY CONFERENCE

OSBORNE A. BRINES, M.D., Detroit

Professor of Pathology, Wayne University College of Medicine

GORDON B. MYERS, M.D., Detroit

Professor of Medicine, Wayne University College of Medicine; Head, Department of Medicine, Detroit Receiving Hospital

LAWRENCE REYNOLDS, M.D., Detroit

Chief of Radiological Department of Harper Hospital; Chief of Staff of Harper Hospital; Professor of Radiology and Head of Department of Radiology, Wayne University College of Medicine

- 5:00 End of Second Assembly

PROGRAM

ENTERTAINMENT NIGHT

Grand Ballroom, Book-Cadillac Hotel

P.M.

8:30 Presentation of scroll to Michigan's Foremost Family Physician for 1950—Lunette I. Powers, M.D., Muskegon

Response by Dr. Powers

8:30 **DON LARGE and his FIVE GRENADIERS**—Finest choral group of its kind in the business today. Five voices—varied repertoire of solos and quintette numbers—colorful wardrobe

9:00 p.m. to 1:00 a.m.—**BATTLE OF MUSIC—THE OLD vs. THE NEW!**

(a) **THE OLD-TIMERS**—Gay music for Square Dances and Quadrilles—with a caller for the sets who gives an outline of the steps of each dance—loads of fun for beginners and experts in Square Dancing

(b) **REG THORNTON and his ORCHESTRA**—Detroit's outstanding band, playing South American as well as the sweet numbers.

All registrants and their ladies are cordially invited to attend.

No admission fee—merely show your registration badge

HOST: MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

Thursday, March 15, 1951

Book-Cadillac Hotel

A.M.

8:30 REGISTRATION—Fifth Floor

EXHIBITS OPEN—Fourth Floor

THIRD ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

RICHARD M. McKEAN, M.D., Detroit, *Chairman*

9:00 "Androgens and Estrogens in General Practice"

WILLARD O. THOMPSON, M.D., Chicago

Clinical Professor of Medicine, University of Illinois College of Medicine; Managing Editor, "Journal of Clinical Endocrinology"; Editor, "Year Book of Endocrinology"; Editor, "American Lectures in Endocrinology"; President-Elect American Goiter Association

9:30 "Management of Edema in Obstetrics and Gynecology"

WILLIS E. BROWN, M.D., Little Rock, Arkansas

Professor and Head, Department of Obstetrics and Gynecology, University of Arkansas School of Medicine

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "Pleural Effusion"

G. THOMAS McKEAN, M.D., Detroit

Assistant Professor of Clinical Medicine, Wayne University College of Medicine; Associate Attending Physician at Harper and Receiving Hospitals, Detroit; Attending Consultant at Dearborn's Veterans Hospital and Herman Kiefer Hospital

11:20 "Anesthesia in Chest Surgery"

WARREN K. WILNER, JR., M.D., Ann Arbor

Assistant Professor of Anesthesiology; Acting Director of the Department of Anesthesiology, University of Michigan



O. A. BRINES, M.D.



G. B. MYERS, M.D.



L. REYNOLDS, M.D.



W. O. THOMPSON, M.D.



W. E. BROWN, M.D.



G. T. McKEAN, M.D.



B. R. CORBUS, M.D.



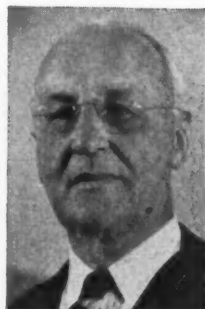
A. C. CURTIS, M.D.



J. E. GORDON, M.D.



A. J. FRENCH, M.D.



E. A. GRAHAM, M.D.



S. GIBSON, M.D.



A. D. RUEDEMANN, M.D.

PROGRAM

- 11:40 "The Neglected Field of Minor Surgery"
ROBERT H. DENHAM, M.D., Grand Rapids
*Consulting Staff of Blodgett Memorial Hospital and
St. Mary's Hospital, Grand Rapids*

M

- 12:00 End of Third Assembly

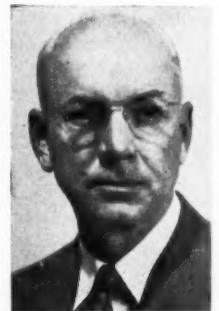
P.M.

- 12:15 LUNCHEON, English Room, Book-Cadillac Hotel
BURTON R. CORBUS, M.D., Grand Rapids, *Chairman*

1:15 THE R. S. SYKES LECTURE

"Common Errors in the
Diagnosis of Broncho-
genic Carcinoma, with
Special Reference to Vi-
rus Pneumonia"

EVARTS A. GRAHAM, M.D.
St. Louis, Missouri
*Professor and Head of
Department of Surgery,
Washington University
School of Medicine; and
Surgeon-in-Chief of
Barnes Hospital*



R. S. SYKES, D.D.S.

FOURTH ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

JOHN M. SHELDON, M.D., Ann Arbor, *Chairman*

P.M.

2:00 "Contact Dermatitis"

ARTHUR C. CURTIS, M.D., Ann Arbor

*Professor and Director, Department of Dermatology
and Syphilology, University of Michigan Medical
School*

2:20 "The Recognition of Heart Disease in Children"

STANLEY GIBSON, M.D., Chicago

*Emeritus Professor of Pediatrics, Northwestern
University Medical School, and Consultant in
Cardiology, Children's Memorial Hospital*

2:40 "Epidemiology of Accidents"

JOHN E. GORDON, M.D., Boston, Massachusetts

*Professor of Preventive Medicine and Epidemiology,
Harvard School of Public Health*

3:00 INTERMISSION TO VIEW EXHIBITS

4:00 "Exophthalmos"

ALBERT D. RUEDEMANN, M.D., Detroit

*Professor of Ophthalmology, Wayne University
College of Medicine, Head Division of Ophthal-
mology, Harper Hospital; Chief Ophthalmologist
Receiving Hospital, Detroit*

4:20 CLINICAL PATHOLOGICAL CONFERENCE

ARTHUR C. CURTIS, M.D., Ann Arbor

*Professor and Director, Department of Dermatology
and Syphilology, University of Michigan Medical
School*

ADAM J. FRENCH, M.D., Ann Arbor

*Associate Professor of Pathology, University of
Michigan Medical School*

- 5:00 End of Fourth Assembly

JMSMS

PROGRAM

— No Thursday Night Program —

Friday, March 16, 1951

Book-Cadillac Hotel

A.M.

8:30 REGISTRATION—Fifth Floor

EXHIBITS OPEN—Fourth Floor

FIFTH ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

JAMES H. FYVIE, M.D., Manistique, *Chairman*

9:00 "Frequency of Colitis in Veterans"

HAROLD J. KULLMAN, M.D., Dearborn

Associate Professor of Clinical Medicine, Wayne University College of Medicine



H. J. KULLMAN, M.D.

9:15 "The Medical and Surgical Approach to Infectious Diseases of the Colon"

RUSSELL S. BOLES, M.D., Philadelphia

Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania; Chief Medical Service, Philadelphia General Hospital; Past President American Gastroenterology Association; Past Chairman Section on Gastroenterology and Proctology, American Medical Association



R. S. BOLES, M.D.

9:40 "Dietary Therapy in Pregnancy and its Complications"

ALLAN C. BARNES, M.D., Columbus, Ohio

Chief Department of Obstetrics and Gynecology, Ohio State University College of Medicine



A. C. BARNES, M.D.



R. M. NESBIT, M.D.

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "The Diagnosis and Management of Croup at Infancy"

HARRY A. TOWSLEY, M.D., Ann Arbor

11:20 "Congenital Valve Obstructions in the Urinary Tract of Infants"

REED M. NESBIT, M.D., Ann Arbor

Professor of Surgery, Section of Urology, University Hospital; Chief of Section of Urology, University Hospital and Professor of Surgery, University of Michigan Medical School, Ann Arbor

RICHARD L. THIRLBY, M.D., Co-Author

11:40 "The Geriatric Philosophy"

FREDRICK C. SWARTZ, M.D., Lansing

Chief of Medicine, St. Lawrence Hospital

M.

12:00 End of Fifth Assembly



F. C. SWARTZ, M.D.

P.M.

12:15 LUNCHEON, English Room, Book-Cadillac Hotel

CLARENCE E. UMPHREY, M.D., Detroit, *Chairman*

1:15 "The Metabolic Response to Surgery"

FRANCIS D. MOORE, M.D., Boston, Massachusetts

Moseley Professor of Surgery, Harvard Medical School; Surgeon-in-Chief Peter Bent Brigham Hospital



F. D. MOORE, M.D.

JANUARY, 1951

PROGRAM



J. W. CONN, M.D.



W. P. HOLBROOK, M.D.



C. A. RAGAN, JR., M.D.



H. E. UNGERLEIDER, M.D.



F. J. SMITH, M.D.



A. E. DORFMAN, M.D.

SIXTH ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

JOHN E. MANNING, M.D., Saginaw, *Chairman*

2:00 ACTH and Cortisone Panel

JEROME W. CONN, M.D., Moderator, Ann Arbor

Professor of Internal Medicine, University of Michigan; Director, Division of Metabolism and Endocrinology, University Hospital, Ann Arbor

W. PAUL HOLBROOK, M.D., Tucson, Arizona

Senior Medical Consultant, St. Mary's Hospital and Tucson Medical Center; Medical Consultant to Surgeon General, U.S.A.F.

FRANCIS D. MOORE, M.D., Boston, Massachusetts

CHARLES A. RAGAN, JR., M.D., New York, New York

Assistant Attending Physician Presbyterian Hospital, New York; Secretary-Treasurer American Rheumatism Association

3:00 FINAL INTERMISSION TO VIEW EXHIBITS

3:30 ACTH and Cortisone Panel (continued)

Doctors Conn, Holbrook, Moore, and Ragan

4:30 Question and Answer Period on ACTH and Cortisone Panel

5:00 End of Sixth Assembly and of the Institute

MICHIGAN HEART ASSOCIATION

Second Annual Heart Day Saturday, March 17, 1951

A.M.

9:00 "920 Cases of Myocardial Infarction—A Study of the Acute Phase"

F. JANNEY SMITH, M.D., Henry Ford Hospital, Detroit

10:00 "Blood Lipids and Human Arteriosclerosis"

HARRY E. UNGERLEIDER, M.D., Medical Director, The Equitable Life Assurance Society, New York.

11:00 "The Present Status of ACTH and Cortisone in Rheumatic Fever"

ALBERT DORFMAN, M.D., The University of Chicago, Chicago, Illinois

M

12:00 LUNCHEON

Second Annual Meeting of Members of the Michigan Heart Association.

All members of the Michigan State Medical Society are cordially invited to attend.

For list of exhibitors at the Institute, see Page 93

You Can Assure...adequate water, bulk, dispersion

with METAMUCIL...

Smoothage Therapy in Constipation

ADEQUATE WATER...

Metamucil powder is taken with a full glass of cool liquid and may be followed by another glass of fluid if indicated. This assures the desired water volume conducive to physiologic peristalsis.

ADEQUATE BULK...

Mixed with water, Metamucil produces a large quantity of a bland, plastic, water-retaining bulk.

ADEQUATE DISPERSION...

This bland mass mixes intimately with the intestinal contents and is extended evenly throughout the digestive tract.



Metamucil does not interfere with the digestion or the absorption of oil-soluble vitamins; is nonirritating; does not interfere with water balance; does not cause straining or impaction.

METAMUCIL® is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



Second Michigan Industrial Health Day

Wednesday, April 4, 1951

Rackham Memorial Building

100 Farnsworth Avenue

Detroit 12, Michigan

Sponsored by the Michigan Association of Industrial Physicians and Surgeons; Wayne University College of Medicine; Michigan State Medical Society's Committee on Industrial Health; Division of Industrial Health of the Michigan Health Dept.; Medical School of the University of Michigan; Michigan State Association of Industrial Nurses; the School of Public Health of the University of Michigan, and the Michigan Industrial Hygiene Society.

General Chairman for the Day

CARL HANNA, M.D., Detroit

PROGRAM

Morning Session

- A.M.
- 9:00 **Registration:** Rackham Memorial Bldg., Main Auditorium.
- 9:30 **"Introduction to the Day's Activities."**
CLIFFORD H. KEENE, M.D., Medical Director, Kaiser-Frazer Corp., Willow Run, Michigan.
- 9:40 **"New Developments in Industrial Surgery."**
HARRY E. MOCK, JR., M.D., Northwestern University College of Medicine, Department of Surgery, Chicago, Illinois.
- 10:00 **"Developments in Industrial Nursing."**
HELEN DE COURSEY, R.N., Kelsey Hayes Wheel Company, Detroit.
- 10:20 **"The Rising Toll of Obesity in Industry."** America's number one health problem.
ALFRED W. PENNINGTON, M.D., Medical Department, E. I. DuPont Co., Wilmington, Delaware.
- 10:40 **"Beryllium Poisoning."** The newest major occupational disease.
OSCAR A. SANDER, M.D., Marquette University College of Medicine, Milwaukee, Wisconsin.
- 11:00 **"International Industrial Medicine."** The United States is carrying Industrial Medicine to other lands.
ROBERT C. PAGE, M.D., General Medical Director, Standard Oil Co. of New Jersey, New York, N. Y.
- 11:45 **Discussion Leader:**
GORDON H. SCOTT, PH.D., Dean of Medical College, Wayne University, Detroit, Michigan.
- P.M.
- 12:00-2:00 **Lunch Period:** (The dining-rooms of nearby Sheraton Hotel are readily accessible)

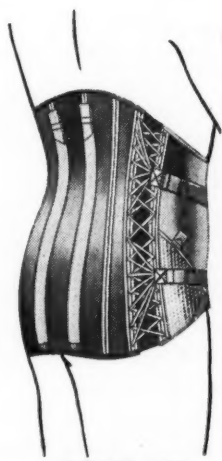
Afternoon Session

- Presiding, HARLEY L. KRIEGER, M.D., Medical Director, Ford Motor Co., Dearborn, Michigan.
- P.M.
- 1:30 **"Defenses Against Atomic Bombing."**
DONALD S. LEONARD, Commissioner, Michigan State Police, East Lansing, Michigan.
- 2:30 **Medical Aspects of Atomic Warfare**
1. **"Effects on Personnel"**
GEORGE A. HARDIE, M.D., Washington, D. C., Assistant to the Chief (in charge of Industrial Health activities) Medical Branch, U. S. Atomic Energy Commission.
 2. **"Management of Injuries"**
CHARLES L. DUNHAM, M.D., Washington, D. C., Chief, Medical Branch, U. S. Atomic Energy Commission, Washington, D. C.
 3. **"Specific Problems for the Industrial Physician"**
JAMES H. STERNER, M.D., Rochester, N. Y., Associate Medical Director, Eastman Kodak Company.
- 4:00 **Discussion Leader and Demonstrator of Radio Activity Measurement Equipment.**
HOMER S. MYERS, Vice President, Radioactive Products, Inc., Detroit, Michigan.
- * * *
- 4:30 **Annual Business Meeting—Michigan Association of Industrial Physicians and Surgeons.**
Presiding, JOSEPH L. ZEMENS, M.D., President, Michigan Association of Industrial Physicians and Surgeons, Detroit, Michigan.
- ### Evening Sessions
- 6:00 **Cocktails:** Available in the Sheraton Hotel.
- 7:00 **Annual Banquet (informal)**
Toastmaster—CLARENCE E. UMPHREY, M.D., Detroit, President, Michigan State Medical Society.
- "The Industrial Worker's Better World."**
DR. LILLIAN M. GILBRETH, Consulting Industrial Engineer, Montclair, New Jersey.
The Inauguration of the Twenty-Five Years Occupational Health Service Group, and the Presentation of Certificates. JOSEPH L. ZEMENS, M.D., presiding.

All members of the Michigan State Medical Society are cordially invited to attend.

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**Fully Adjustable And
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For
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New "Comfortex" Garments Cushioned for Comfort

Freeman's new Comfortex design gives soft, downy comfort never believed possible in surgical garments plus the same fine fit and correct support which have always marked the Freeman line.

Linings and stay covers inside all Freeman corrective garments now feature "Velvesoft" Interior Finish. Soft velveteen cushions the linings and stays. No more hard abrasive lining material to mark flesh and irritate the skin.

Model illustrated No. 422 completely covers sacral and lumbar regions. Provides firm support and correct pressure. Useful after cast removal, and in cases of severe back strain. Back strongly braced by removable stays parallel to spine. Side lace, two pull-up straps. Knitted elastic sections.

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Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

A new antibiotic which may well rival the sulfas, penicillin and streptomycin in its effectiveness against disease has been discovered in the Laboratories of the Michigan Department of Health.

The antibiotic is a product of a peach-colored soil mold, the 3,590th of 17,000 molds tested in the Department's four-year-old antibiotic research program.

Based on its structural form, it has been given the name synnematin (pronounced sin NEE ma tin) which means "fused thread."

Synnematin kills the organisms of several diseases in test tubes and in animals. Tests in humans have not been done.

The new antibiotic is effective against diseases caused by certain Salmonella organisms for which no present adequate treatment exists. Salmonella organisms are the cause of certain types of diarrhea, including the type of infant diarrhea which has caused the deaths of numerous Michigan infants in hospital nurseries. The Salmonellas are also responsible for certain types of septicemia and for typhoid fever.

In the test tube it appears that synnematin may also be effective against tuberculosis, undulant fever and certain streptococcus organisms.

Credited with the discovery are four of the Department's young researchers: Dr. Russell Gottshall, bacteriologist; Dr. John M. Roberts, mycologist; Dr. Lucile Portwood, chemist; and Jay C. Jennings, bacteriologist.

While much additional testing in animals and much purification remains to be done before production for human use can be undertaken, the Department has applied for a patent on the antibiotic in the name of the State of Michigan.

During the summer of 1950 one of the most unique chest x-ray surveys in the history of tuberculosis control was conducted in Michigan through the co-operation of the Michigan Department of Health and other agencies. Targets for the survey were 12,000 merchant seamen assigned to ships of 37 lake steamship companies. X-raying was done as ships went through the Sault Ste. Marie locks, considered one of the most important installations in the Nation's planning for defense. Positive findings were reported by radio telephone to ships under way.

The United States Public Health Service, the Great Lake Carriers Association, and the United States Army Corps of Engineers were the other co-operating agencies in the survey. Except for provision of an x-ray unit by the Public Health Service, all costs of the program were defrayed by the Lake Carriers Association, which initiated the survey program.

Because of the imposition of more stringent security regulations for the Soo Locks, after the chest survey program was planned, a total of only 4,257 x-rays were taken. As only four men at a time were permitted to

leave a ship while it was in the Locks, it was impossible to reach the goal of 12,000 x-rays in the time of the project.

Follow-up is not completed. However, a rate of tuberculosis findings of 18.6 per thousand was indicated. Tuberculosis findings were as follows:

Minimal	Moderately Advanced	Far Advanced	Other Tbc.	Total Tbc. Findings
50	22	6	1	79

There were forty-two nontuberculosis abnormalities indicated.

Included in the survey were Soo Locks personnel. No chest abnormalities were found in this group.

* * *

More than 800 people interested in the field of public health in Michigan attended the thirtieth annual Michigan Public Health Conference in Grand Rapids. Of these, 530 were registered conference participants.

New drugs and diagnostic procedures, the constructive side of atomic energy and the role of public health people in civilian defense were discussed as well as mutual problems.

The Michigan Association of Public Health Dentists and Dental Hygienists were accepted as affiliates of the Michigan Public Health Association at the conference.

The Michigan Public Health Association endorsed proposed legislation to provide more state funds for local health departments. Both the Michigan Public Health Association and the Michigan Health Officers Association passed resolutions commending Dr. Albert Heustis, State Health Commissioner, for his leadership in public health in Michigan and pledging their continued support.

New Michigan Public Health Association officers are: President, Marjorie Delavan, Chief, Section of Education, Michigan Department of Health; President-Elect, Patricia Walsh, R.N., Director of Nursing, Washtenaw County Health Department, Ann Arbor; Vice President, H. E. Cope, M.D., Chief, Section of Clinical Pathology, Michigan Department of Health; Secretary-Treasurer, LaRue Miller, Chief, Environmental Sanitation Section, Michigan Department of Health; Representative on the Governing Council, American Public Health Association, George C. Stucky, M.D., Director, Eaton County Health Department.

The Michigan Health Officers' Association elected: President, M. R. French, M.D., Director, Branch-Hillsdale Health Department; Vice President, O. D. Stryker, M.D., Director Macomb County Health Department; Secretary, Vergil Slee, M.D., Director, Barry County

(Continued on Page 82)

High Vitamin B₁₂ Content...

Another Reason for Liberal Meat Intake

According to rapidly accumulating clinical and laboratory observations, the daily ingestion of liberal quantities of meat can effect profound physiologic benefits due to the significant content of vitamin B₁₂, not only in liver and kidney, but also in muscle meats.

Muscle meat is a good source of the newly isolated vitamin B₁₂; liver and kidney are especially high in their vitamin B₁₂ content, while plant foods are negligible sources of this nutrient.¹ By rat assay, the minimum amounts of vitamin B₁₂ in muscle meat range from 0.5 to 3 mcg. per 100 Gm.; minimum values for beef liver and kidney are 15 and 20 mcg., respectively.²

B₁₂ is among the most potent of known microbiologically active substances.³ Animal studies indicate that it increases the ability of the normal mammal to utilize protein.⁴ With a high protein diet, 0.01 mcg. of vitamin B₁₂ per day was found to increase significantly the growth rate of B₁₂ deficient rats. In another study, growth response of B₁₂ depleted rats was proportional to the B₁₂ in the ration within the critical range of 0.025 to 0.1 mcg. per rat day.⁵

About 1 mcg. of vitamin B₁₂ daily, administered intramuscularly, constitutes an effective dose in pernicious anemia. In a recent clinical study of young children manifesting vitamin B₁₂ deficiency as evidenced by malnutrition and growth failure, oral administration of 10 mcg. of vitamin B₁₂ daily for eight weeks induced marked responses in growth; notable increases in vigor, alertness and better general behavior; and improved appetite.⁶

Here again is further evidence of the broad, over-all nutrient contribution meat makes to the dietary. Eaten two or three times daily, it supplies not only generous amounts of high quality protein, but also significant quantities of vitamin B₁₂ and other essential B complex vitamins, and of iron.

(1) Schweigert B. S.: Significance of Vitamin B₁₂ and Related Factors, J. Am. Dietetic Assoc. 26:782 (Oct.) 1950.

(2) Lewis, U. J.; Register, U. D.; Thompson, H. T., and Elvehjem, C. A.: Distribution of Vitamin B₁₂ in Natural Materials, Proc. Soc. Exper. Biol. & Med. 72:479 (Nov.) 1949.

(3) Shorb, M. S.: Activity of Vitamin B₁₂ for the Growth of *Lactobacillus lactis*, Science 107:397 (Apr. 16) 1948.

(4) Hartman, A. M.; Dryden, L. P., and Cary, C. A.: The Role and Sources of Vitamin B₁₂, J. Am. Dietetic Assoc. 25:929 (Nov.) 1949.

(5) Frost, D. V.; Fricke, H. H., and Spruth, H. C.: Rat Growth Assay for Vitamin B₁₂, Proc. Soc. Exper. Biol. & Med. 72:102 (Oct.) 1949.

(6) Wetzel, N. C.; Fargo, W. C.; Smith, I. H., and Helikson, J.: Growth Failure in School Children as Associated with Vitamin B₁₂ Deficiency—Response to Oral Therapy, Science 110:651 (Dec. 16) 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



American Meat Institute
Main Office, Chicago...Members Throughout the United States

(Continued from Page 80)

Health Department; Treasurer, C. A. Neafie, M.D., Director, Pontiac Health Department.

* * *

The largest volume of work ever done in its history was completed by the Division of Laboratories of the Michigan Department of Health in the calendar year 1950. Approximately 1,125,765 diagnostic tests were performed to assist physicians in identifying disease and 3,410,206 doses of serums and vaccines were produced and distributed for the prevention, diagnosis or treatment of illness in Michigan people. The increase occurred despite a reduction in the operating budget of the Laboratories and despite elimination of certain routine laboratory procedures.

* * *

"Michigan's Health at the Half Century," an article in the December issue of *Michigan Public Health*, gives a summary of the activities of the Michigan Department of Health during the calendar year 1950. Copies of the year-end summary issue or a year's subscription to the magazine are available without cost from the Department.

* * *

Robert Hall, M.D., Director of the Isabella County Health Department since April, 1947, has resigned effective January 1, 1951. He plans to enter private practice in Mt. Pleasant.



**in sinusitis arthritis
neuralgias traumatism
BURDICK ZOALITE
INFRA-RED LAMPS**

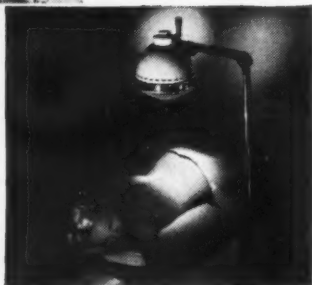
A Burdick Zoalite, by increasing the local circulation and relaxing spasm, can accomplish considerable in relieving the distress of many local inflammatory conditions.

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The Z-12 Zoalite — 600 watts — a professional infra-red unit.



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AND
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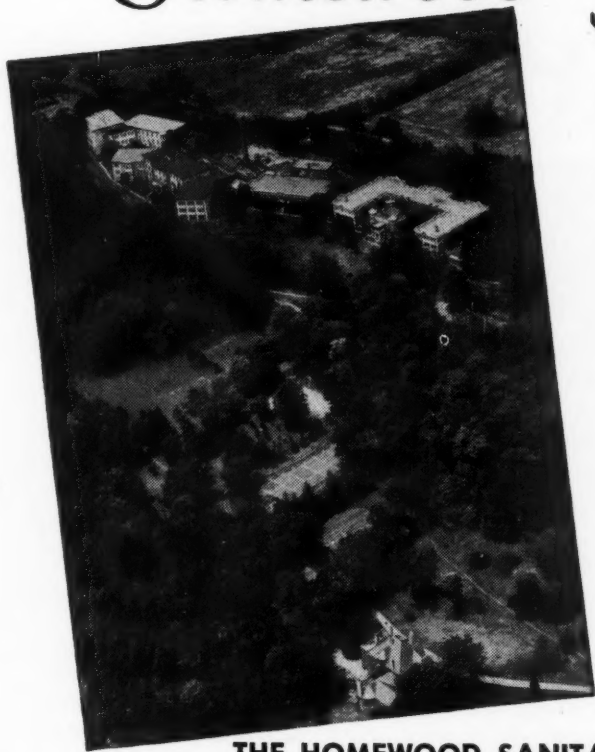
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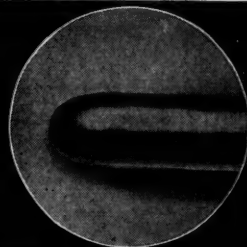
Homewood is a fully equipped 200 bed Private Sanitarium with its over 90 acres of beautiful countryside situated at Guelph, Ontario, only sixty miles from Toronto. Nervous and mild mental disorders and also a limited number of suitable cases of long standing mental illness, habit cases and cases of senility are admitted. Under the direction of a staff of Psychiatric Specialists and Physicians, all modern methods of treatment are available, including Psychotherapy, Insulin, Electroshock and Electronarcosis combined with fully up-to-date Physiotherapy, Occupational and Recreational therapy. Rates are from \$56.00 to \$75.00 per week which includes comfortable accommodation, meals, ordinary medicine and nursing care, ordinary laboratory procedures, physiotherapy, psychotherapy and occupational and recreational therapy. Write for illustrated folder.

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Medical Supt.

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NEWS MEDICAL

MT. CARMEL HOSPITAL CLINIC DAY

Wednesday, January 31, 1951

- 9:00 a.m. Maurice H. Seevers, M.D., Professor of Pharmacology, University of Michigan, Ann Arbor
"Recent Advances in Analgesia and Analgetic Drugs"
- 9:45 a.m. Speaker to be announced.
- 10:30 a.m. Ralph Reis, M.D., Professor of Obstetrics and Gynecology, Northwestern University, Chicago.
"The Management of Prolonged Labor."
- 11:15 a.m. William Boyd, M.D., Professor of Pathology, University of Toronto, Toronto, Ontario.
"Pathology of Intercellular Substance."
- 12:30 p.m. Complimentary Luncheon.
- 2:00 p.m. Mitchell I. Rubin, M.D., Professor of Pediatrics, University of Buffalo, Buffalo, N. Y.
"Renal Failure in Childhood."
- 2:45 p.m. Warren O. Nelson, M.D., Professor of Anatomy, University of Iowa, Iowa City.
"Interpretation of the Testicular Biopsy."
- 3:30 Speaker to be announced.

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

THE DEPARTMENT OF POSTGRADUATE MEDICINE

University Hospital, Ann Arbor, Michigan

BRIEF REVIEW COURSES FOR PRACTICING PHYSICIANS

1951

- Anatomy(Thursdays) Feb. 15-May 31
PediatricsFeb. 28-March 3
Internal Medicine
Diseases of the
Gastro-Intestinal Tract.....April 23-27
Diseases of the HeartMarch 19-23
Rheumatic DiseaseApril 2-6
Recent Advances in Therapeutics.....May 3-5
Endocrinology and Metabolism.....Mar. 26-30
Diseases of the Blood.....April 16-20
AllergyApril 9-13
Electrocardiographic Diagnosis.....Aug. 27-Sept. 1
Neurology, ClinicalMay 14-17
Obstetrics and GynecologyFeb. 19-Mar. 3
Ophthalmology ConferenceApril 23-25
Roentgenology, DiagnosticApril 16-20
For further information about the above listed courses, write to

Howard H. Cummings, M.D., Chairman
Department of Postgraduate Medicine
2040 University Hospital
Ann Arbor, Michigan

The Jackson County Medical Society sponsored a dinner in Jackson on December 12 at which the members of the County Board of Supervisors, the City Commission, the Mayor, the City Manager, and the Editor of the *Jackson Citizen Patriot* were guests. The meeting was addressed by A. E. Heustis, M.D., State Commissioner of Health, who spoke on "The Workings and Structure of a City-County Health Unit."

* * *

The Michigan Health Officers Association, at its November 30 annual meeting in Grand Rapids, elected M. R. French, M.D., Coldwater, as its new President (Dr. French is Secretary of the MSMS Section on Public Health and Preventive Medicine).

O. D. Stryker, M.D., of Mt. Clemens was chosen as Vice President, Vergil N. Slee, M.D., of Hastings was re-elected as Secretary, and C. A. Neafie, M.D., Pontiac, is the Treasurer. On the Board of Directors are W. B. Prothro, M.D., Kalamazoo; V. K. Volk, M.D., Saginaw; Clifford Merritt, M.D., Lake City, and Ralph TenHave, M.D., Holland.

* * *

Officers of the Michigan Public Health Association, elected in Grand Rapids on November 30 at the 30th annual session, are: President: Marjorie Delavan, Lansing; President-Elect, Patricia Walsh, Ann Arbor; Vice President, H. E. Cope, M.D., Lansing; Secretary-Treasurer, LaRue Miller, Lansing, and Representative on Governor's Commission on MPHA, G. C. Stucky, M.D., Charlotte.

* * *

The 11th Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1951 for the best unpublished essay on any subject of general medical interest. The Society offers a cash prize of \$100, a gold medal, and a certificate of award. For the essay rated as second and third best, certificates of merit are also granted. For full information, write Harold Swanberg, M.D., Secretary, 209-224 W.C.U. Building, Quincy, Ill.

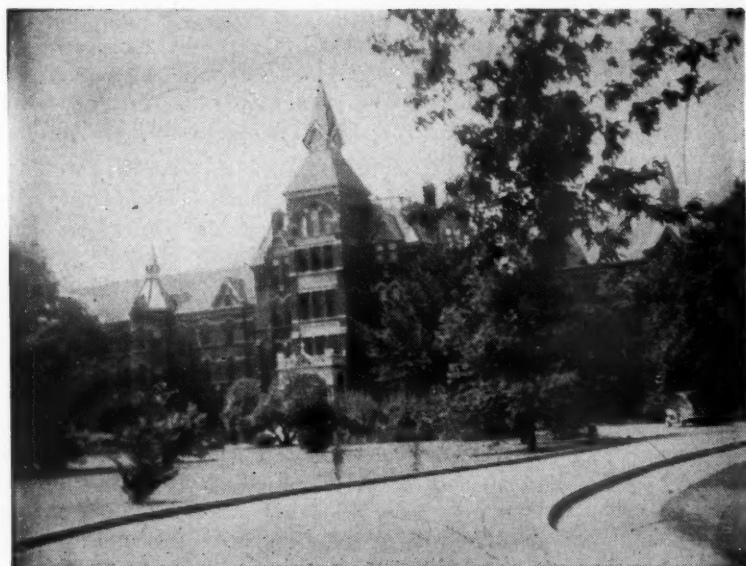
* * *

Unqualified satisfaction and success marked the Postgraduate Clinical Seminar in color television presented in Detroit on November 15-16, under the auspices of the Academy of General Practice of Wayne County, the Wayne County Medical Society, the Grace Hospital, and Smith, Kline and French Laboratories of Philadelphia. Over 400 doctors of medicine from Michigan and Northern Ohio and Western Canada viewed the latest methods of treating some of the ailments they meet most often, via discussion and clinical programs over color television. The meeting was held in the

(Continued on Page 86)

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ST. JOSEPH'S RETREAT



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*Under direction of
Daughters of Charity
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3 FORMS: Oral tablets (5 mg.); syrup (5 mg. per teaspoonful); and powder (for compounding). Average adult dose 5 mg. May be habit forming; narcotic blank required. Literature sent on request.

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DETROIT 1, MICH.**

(Continued from Page 84)

Crystal Ballroom of the Masonic Temple. Operations were televised from the Grace Hospital, Detroit.

* * *

Charles B. Shuman, President of the Illinois Agricultural Association, called upon farmers to join other groups in demanding the ouster from office of Agriculture Secretary Brannan and Federal Security Administrator Ewing. In a speech before the Association's 36th annual meeting in Chicago, Mr. Shuman said that these two members of the Washington administration were responsible for sponsoring plans to socialize agriculture and medicine, respectively.

* * *

MSMS President C. E. Umphrey, M.D., Detroit, addressed the Livingston County Medical Society on December 1 at Michigan State Sanatorium at Howell. His subject was "Medical Strategy." Doctor Umphrey also addressed the Northeastern Lions Club of Detroit on November 27. His subject was "National Confusion."

* * *

Leo H. Bartemeier, M.D., Detroit, has been appointed a member of the National Advisory Mental Health Council to the National Institute of Health, Public Health Service, Federal Security Agency.

* * *

The University of Michigan School of Public Health, Ann Arbor, has been granted \$25,000 for the project "Instruction for the Prevention of Cancer," by the National Cancer Institute of the Public Health Service, Federal Security Agency.

Wayne University College of Medicine (M. Mason Guest, M.D.) has also received a grant of \$5,022 from the same source for "An Investigation of the Fibrinolytic Enzyme and Inhibitor Systems in Blood and Urine, and the Relationship to Cancer." These are two of the special 17 cancer control grants made by the National Cancer Institute, totaling \$324,525.

* * *

The University of Michigan (Aaron Bunsen Lerner, M.D., Ann Arbor) has received a grant of \$8,748 from the National Cancer Institute, Public Health Service, Federal Security Agency, for "An Investigation of the Bio-chemistry, Development and Diagnosis of Melanomas."

From the same source, the Detroit Institute of Cancer Research (Ralph M. Johnson, M.D.) received \$6,000 for "Lipid (fats) Studies in Relation to Carcinogenesis."

* * *

The Michigan State Medical Technicians Society recently elected the following officers: President, Eleanor Hulton, Saginaw; Vice President, Dorothy Hitchcock, East Lansing; Recording Secretary, Mrs. Betty Gillette, Flint; Corresponding Secretary, Ruth Hetzer, Battle Creek; and, Treasurer, Angela Serefine, Detroit.

* * *

The 1950-1951 Officers of the Michigan State Medical Assistants Society, elected at its meeting of September 20, 1950, are: President: Mrs. Irma Nelson, Lansing;

(Continued on Page 88)

ANNUAL CLINICAL CONFERENCE CHICAGO MEDICAL SOCIETY

March 6, 7, 8, 9, 1951 • Palmer House, Chicago

A conference planned to keep physicians abreast of the new things which are developed from year to year.

Special feature of the 1951 Conference—DAILY TEACHING DEMONSTRATION PERIODS from 11:00 to 12:00 noon and 1:30 to 3:00 P.M. Demonstrations will cover:

Amputations and Prostheses

Patients Treated with ACTH and Cortisone

Dermatologic Clinic

Organization of a Blood Bank

Neurological Clinic

Sterility Tests

Speech Without Larynx

Proper Application of Casts and Splints in Fractures

Local Anesthesia

Fluid and Electrolytic Balance in Surgery

Use and Misuse of Obstetrical Forceps

Common Problems in X-Ray Interpretations

Laboratory Tests (Diabetes, Proper use of Insulin, Prothrombin Tests)

Thirty-four outstanding teachers and speakers will present half-hour lectures on subjects of interest to both general practitioner and specialist.

Four PANELS on timely topics

Scientific exhibits worthy of real study and helpful and time-saving technical exhibits.

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.



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Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky... the same high quality the world over.



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WALKER**
BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N. Y., Sole Importer

(Continued from Page 86)

President-Elect, Miss Freda Heidelberger, Detroit; Recording Secretary, Miss Phyllis Marquardt, Kalamazoo; Corresponding Secretary, Mrs. Leah Rhodes, Lansing; and, Treasurer, Mrs. Elizabeth Peck of Detroit.

* * *

The Ingham County Medical Society (Lansing) took action to pay the state and AMA medical dues of members of the Ingham County Medical Society who are on military duty, during their periods of service.

* * *

The Lansing Life Underwriters Association adopted a resolution against compulsory health insurance on October 11, 1950. The resolution reads:

"Resolved, by the unanimous vote of the membership of the Lansing Life Underwriters Association of Lansing, Michigan, at its regular monthly meeting, October 11, 1950, that this Association is opposed to any form of legislation to provide Compulsory Insurance for Health, Hospital Care, Medical or Surgical Services, to be controlled or administered by any Federal Government Agency, and

"Be it further resolved, that a copy of this Resolution be transmitted to our Representatives and Senators in the Congress of the United States; and that they be and hereby are respectfully requested to use every effort at their command to prevent the enactment of any legislation for the establishment of any plan of compulsory health insurance."

* * *

The Ingham County Medical Society Bulletin recently published a statement on the medical care program and health facilities available in Ingham County (Lansing). The statement was in the form of a letter addressed to the Ingham County Citizens Committee on Children and Youth (part of the White House Conference on Youth). The author of the statement was Josef Rozan, M.D., Lansing, President-Elect of the Ingham County Medical Society.

* * *

The Association of State and Territorial Health Officers, at a meeting held recently in Washington, re-affirmed its opposition to national compulsory health insurance and renewed its demand for creation of a federal department of health with cabinet status, under direction of a career physician in public health.

* * *

The Ingham County Medical Society Bulletin publishes a roster of its membership, annually (in the November number).

* * *

The Medical Protective Company's Attorney, Harry W. Ginty, journeyed from Fort Wayne to Saginaw to address the Saginaw County Medical Society at its general meeting of November 28, 1950.

* * *

The Bulletin of the Saginaw County Medical Society lists the birthdays of all members, monthly.

* * *

Health Scheme Is Death Service.—The Bevan health scheme was branded as the "National Death Service" by Sir Herbert Williams, Conservative M.P., at New-castle-on-Tyne yesterday.

(Continued on Page 90)



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A completely equipped sanitarium for the care of
nervous and mental disorders, alcoholism and drug addiction
offering all forms of treatment, including electric shock.

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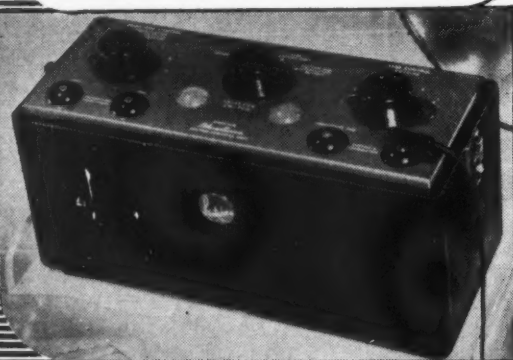
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1. Tube Generated Cutting Current.
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Street _____

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(Continued from Page 88)

"Taking the first two years of the National Health Service, deaths, increased by 88,000," he said. "If the service is responsible for this increase in mortality, then it has killed more people in two years than the 60,000 civilians who were killed by Hitler in the blitz."

Solution to the problem of overcrowded doctors' surgeries, he suggested, was a levy of six-pence for every visit by a patient.—From "The London Mail," published in *The Bulletin*, Genesee County Medical Society, November, 1950.

* * *

Sees State Medicine in Britain Getting Worse.—Miss Elizabeth Wilson, who has been studying and writing on compulsory health insurance for many years, just returned from a three-month investigation of the British system and found conditions there getting worse instead of better.

"Three out of four persons interviewed criticized it severely."

"The people who have not used the service resent the deduction of a tax for it every week."

"Doctors frequently see as many as ninety patients in three hours."

"Many doctors and dentists resent their lack of freedom. A doctor has to apply to the local executive council for permission to go on an extended vacation, to move from one house to another, or even change his hours of consultation."—*Bulletin*, Berrien County Medical Society, November, 1950.

* * *

Selective Service has three boards of appeal, composed of a doctor of medicine, an attorney, an industrialist, a representative of labor, and a representative of agriculture.

R. R. McCrumb, M.D., of Lansing, C. D. Monroe, M.D., of Jackson, and Josef Rozan, M.D., of Lansing, are the medical representatives of the three boards of appeal to Selective Service of Michigan.

* * *

MSMS Annual Session Speakers.—Three hundred and twenty-five (325) guest essayists from out of Michigan have been featured on the Assembly programs at MSMS Annual Sessions from 1936 through 1950, inclusive. Of these, only thirty-eight were used more than once in that fifteen-year period.

* * *

Important meetings you will want to attend:

1. Michigan Postgraduate Clinical Institute—Detroit, Wednesday, Thursday, Friday, March 14-15-16, 1951. (See detailed Program on Pages 70-76.)
2. Michigan Heart Day (sponsored by Michigan Heart Association)—Detroit, Saturday, March 17, 1951. (Book-Cadillac Hotel.)
3. Michigan Industrial Health Day—Detroit, April 4, 1951. (Rackham Building.)
4. American Medical Association Annual Session—Atlantic City, June 11-15, 1951.
5. MSMS Annual Session—Grand Rapids, September 26-27-28, 1951.

(Continued on Page 92)

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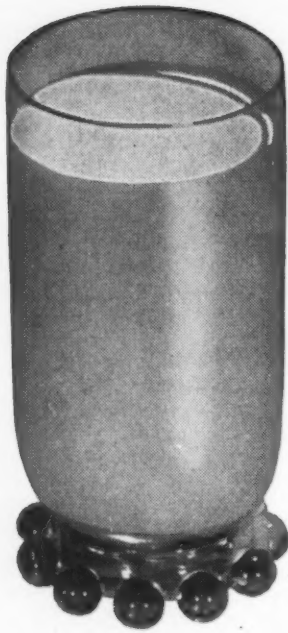
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(Continued from Page 90)

R. S. Sykes, D.D.S., Muir, Michigan, is the sponsor of the annual Sykes Lecture presented on the occasion of the Michigan Postgraduate Clinical Institute. This year the Sykes Lecture will be presented on Thursday, March 15, in the English Room of the Book-Cadillac Hotel, Detroit, as a feature of the Thursday luncheon. Evarts A. Graham, M.D., St. Louis, Missouri, the 1951 lecturer, will speak on "Common Errors in the Diagnosis of Broncho-Genic Carcinoma."

Sixty-day billing clause in Afflicted and Crippled Children Laws.—Payment to physicians under these two Michigan Acts is governed by a sixty-day billing clause. This is spelled out in the two laws which the Michigan Crippled Children Commission must administer.

The Crippled Children Act in Section 30 (Compiled Laws, Article 722.230) states: "This affidavit and statement shall in all instances be furnished not later than sixty days after the release or discharge of a child from the hospital."

The Afflicted Children Act in Section 14 (Compiled Laws, Article 722.314) states: "Payment shall be refused on any billing rendered sixty days or more after the discharge of the patient from the hospital."

Inasmuch as the Afflicted and Crippled Children Laws penalize doctors, by the loss of their fees, if they fail

to bill promptly, the Michigan State Medical Society recommends that doctors of medicine taking care of crippled and of afflicted children should **BILL MONTHLY** for all services rendered, direct to the Michigan Crippled Children Commission, Hollister Building, Lansing, Michigan. Make this a habit—**bill monthly for all services rendered.** In the case of afflicted and crippled children, do not depend upon the hospital to do your billing for you. Send your statement direct to the MCCC.

* * *

The Central Medical Society of Wayne County is offering a \$50 award to any hospital resident for the best original paper on a medical subject. The winner will present his manuscript before Central Medical Society at one of its Tuesday luncheon meetings at the Wayne County Medical Society Headquarters. For full information write: R. W. Monto, M.D., Chairman Program Committee, Central Medical Society, Wayne County, Henry Ford Hospital, Detroit.

* * *

One Hundred Books for the Doctor.—For many years William J. Stapleton, Jr., M.D., of Detroit has published in the *Detroit Medical News* a list of one hundred books that are of especial interest to the doctor. This year (in the December 4, 1950, number), the first book on his list is "Saw-Ge-Mah," the book which we reviewed during the year, written by one of our members, Louis J. Garipey, M.D.

EXHIBITORS—1951 MICHIGAN POSTGRADUATE
CLINICAL INSTITUTE

	Booth Number
A. S. Aloe Co., St. Louis, Mo.	55
Americana Corp., Chicago.....	60
Ames Co., Inc., Elkhart, Ind.	27
Ayerst, McKenna & Harrison, Ltd., New York	37
Baker Labs., Cleveland	22
Bilhuber-Knoll Corp., Orange, N. J.	26
Borden Co., New York	50
Camel Cigarettes, New York	31, 32
Cameron Surgical Specialty Co., Chicago	20
Chicago Dietetic Supply House, Inc., Chicago	10
Ciba Pharmaceutical Products, Inc., Summit, N. J.	67
Coca-Cola Co., Atlanta, Ga.	65, 66
Coreco Research Corp., New York	41
Cottrell-Clarke, Inc., Detroit	23
Davis & Geck, Inc., Brooklyn, N. Y., 63 & Cinema Room	
Doho Chemical Corp., New York	25
Farnsworth Labs., Chicago	15
Gerber Products Co., Fremont, Mich.	30
Grune & Stratton, Inc., New York	14
Hack Shoe Co., Detroit	3
Hanovia Chemical & Mfg. Co., Newark, N. J.	47
J. F. Hartz Co., Detroit	42
H. J. Heinz Co., Pittsburgh, Pa.	56
Holland-Rantos, Inc., New York	54
G. A. Ingram Co., Detroit	68
Irwin, Neisler & Co., Decatur, Ill.	39
A. Kuhlman & Co., Detroit	1
Lea & Febiger, Philadelphia	70
Lederle Labs., New York	44, 45
Liebel-Flarsheim Co., Cincinnati, Ohio	4, 5
Eli Lilly & Co., Indianapolis, Ind.	61
J. B. Lippincott Co., Philadelphia	24
M & R Dietetic Labs., Inc., Columbus, Ohio	33
Maico Detroit Co., Detroit	69
Maternity Preparations, Rochester, N. Y.	29
Mead Johnson & Co., Evansville, Ind.	71, 72
Medco Products Co., Tulsa, Okla.	35
Medical Aids Inc., Chicago	52
Medical Arts Surgical Supply Co., Grand Rapids, Mich.	64
Medical Protective Co., Fort Wayne, Ind.	11
Merck & Co., Inc., Rahway, N. J.	34
C. V. Mosby Co., St. Louis, Mo.	51
Wm. R. Niedelson Co., Detroit	74
Ortho Pharmaceutical Corp., Raritan, N. J.	17
Parke, Davis & Co., Detroit	6, 7
Pet Milk Sales Corp., St. Louis, Mo.	48
Philip Morris & Co., Ltd., New York	13
Randolph Surgical Supply Co., Detroit	12
A. H. Robins Co., Inc., Richmond, Va.	38
Sanborn Co., Cambridge, Mass.	19
Sandoz Chemical Works, Inc., New York	49
W. B. Saunders Co., Philadelphia	2
Schering Corp., Bloomfield, N. J.	21
G. D. Searle & Co., Chicago	73
Sharp & Dohme, Inc., Philadelphia	18
Smith, Kline & French Labs., Philadelphia	16
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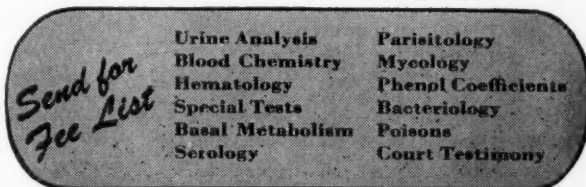
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* * *

Miss Eleanor Fulton, President of the Michigan Society of Medical Technologists, from Saginaw, presided at the meeting which was held at the Fort Shelby Hotel, in Detroit, on October 28, 1950. The program included papers by Dr. Harrison Nelson, of the Upjohn Company; Clarence L. Owen, M.D., Pathologist, Grace Hospital, Detroit; Jean M. Frailing, M.T. (ASCP), Grace Hospital; and Arnold R. Axelrod, M.D., Instructor in Medicine, Wayne University College of Medicine.

The spring meeting will be held in Battle Creek in April.

* * *

Preliminary figures indicate that the poliomyelitis death rate during the first eight months of this year was less than half the rate for the corresponding period last year, according to Federal Security Administrator Oscar R. Ewing.

The percentage of cases resulting in some degree of paralysis was approximately the same for both years, Mr. Ewing said.

Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, pointed out that the estimated

death rate for poliomyelitis during the first eight months of 1949 was 1.3 per 100,000 population, whereas a 10 per cent sample of mortality reports for the corresponding period this year indicates a rate of .6 per 100,000.

"The fact that the incidence of polio continued to increase this year for about three weeks after the close of the eight-month period," Dr. Scheele explained, "may result in a closer approximation of the death rates for 1949 and 1950 when the final tabulations have been made on both epidemics.

"However, both with respect to the number of cases and rates of death, the 1950 epidemic, now fortunately waning rapidly, was somewhat less severe than the record epidemic of 1949. Despite the fact that the incidence and the death rate this year appear to have been considerably lower than last year, the disease still continues to be an important public health problem.

"Thanks in very large measure to the work of the National Foundation for Infantile Paralysis and the public's support of this program, facilities and arrangements for treatment of severe cases have again met the test of a major epidemic. At the same time, reporting and diagnosis of cases has continued to improve.

"Research on this disease, spurred by the epidemics of the last several years, has been stepped up. The severe local outbreak in Paulding County, Ohio, was the subject of an intensive study of a Public Health Service team this year, while in laboratories over the country work is going forward in an effort to find how and under what conditions polio is transmitted."



Most cases of tuberculosis are in advanced stages when reported. Of 3,361 active cases of pulmonary tuberculosis reported in Michigan during 1949, more than three of every four were in advanced stages.

There were 1,297 far-advanced cases or 38.6 per cent of the total; 1,290 moderately advanced (38.4 per cent); 539 minimal (16 per cent); and 235 primary tuberculosis (7 per cent).

In tuberculosis control, the need for early diagnosis is still urgent.

MICHIGAN TUBERCULOSIS ASSOCIATION

No Doctors Inducted Yet.—As of the first of December, no Doctors have been called in the draft. Hundreds have been sent to their draft boards for physical examinations and classifications, but have not yet been ordered into service. Of 276 medical volunteers sent to active duty, 142 were eligible under the draft law.

* * *

The death rate for females is decreasing more rapidly than the rate for males, according to figures released in December by Federal Security Administrator Oscar R. Ewing. The announcement was based on estimates of 1949 mortality statistics compiled by the National Office of Vital Statistics, Public Health Service. Between 1940 and 1949, the death rate for the female population decreased 13 per cent while the rate for males decreased 7 per cent.

Mr. Ewing pointed out that the death rate for every age group has been declining since 1940, the greatest relative decreases occurring in the rates for the younger ages, the smallest in the older ages. The death rate for children one to fourteen years, for example, decreased 40 per cent between 1940 and 1949, while there was only a 10 per cent decrease in the death rate for per-

sons in the age group sixty-five to seventy-four years.

The death rate for males is higher than that for females in each of the age groups. The largest relative difference between the rates for males and females in 1949 was in the age group fifteen to twenty-four years. In this age group, the rate for males exceeded the rate for females by 89 per cent. This is more than three times the percentage difference between the rates for males and females of this age in 1940. The percentage differences between the death rates for males and females in the other age groups over infancy have also increased but not as rapidly.

(This is a surprising accomplishment in face of the horrible state of medical service in America according to Mr. Ewing's blasts for socialized medicine.)

For the United States as a whole, 31,989 cases were reported to the Public Health Service during the first 11 months of this year, as compared with 41,442 for the corresponding period last year. These totals include the peak periods of both epidemics.

(Again, how does this report from Mr. Ewing's office comport with his often expressed opinion that socialized medicine is necessary. This was accomplished under the private enterprise system.)

* * *

Michigan Authors.—

Stuart C. Cullen, M.D., published an article, "The Rational Application of Sedative and Analgesic Drugs," originally in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, and copied in *The General Practitioner of Australia and New Zealand*, September 15, 1950.

Manousos Angel Petrohelos, M.D., Ann Arbor, and John Woodworth Henderson, M.D., of Ann Arbor, published an article, "The Ocular Findings of Intracranial Tumor: A Study of 358 Cases," in the *Transactions of the American Academy of Ophthalmology and Otolaryngology*, November-December, 1950.

Edmond L. Cooper, M.D., of Detroit, and John L. Riker, M.D., of Alpena, published an article, "Malignant Lymphoma of the Uveal Tract," in the *Transactions of the American Academy of Ophthalmology and Otolaryngology*, November-December, 1950.

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*KITE, J. H.: Congenital metatarsus varus. *J. Bone and Joint Surg.*, 32-A:500-506, July, 1950.

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Surgical Anatomy and Clinical Surgery, two weeks, starting February 19, March 19.
Surgery of Colon and Rectum, one week, starting March 5.
Basic Principles in General Surgery, two weeks, starting April 2.
Gallbladder Surgery, ten hours, starting April 23.
Fractures and Traumatic Surgery, two weeks, starting March 19.

GYNECOLOGY—Intensive Course, two weeks, starting February 19.
Vaginal Approach to Pelvic Surgery, one week, starting March 5.

OBSTETRICS—Intensive Course, two weeks, starting March 5.

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PAIN RELIEF DURING LABOR

(Continued from Page 47)

safety and pain relief, resort to the "obstetrical" use of ether or the anesthetic gases. Indeed, it should be made clear—emphatically so—that regional anesthesia techniques are by no means a perfect answer to the problem of obstetrical pain. Their use is safe only when carried out under rigid precautions, and neglect or failure to observe either precautions or contraindications may well lead to trouble.

As physicians, our problem insofar as pain relief during labor is concerned may be summarized as follows:

1. Labor still has as its prime purpose the delivery of a living, healthy child with minimum damage, either physical or psychological, to the mother.
2. All forms of pain relief, no matter how important they appear, play a secondary role in the process of parturition.
3. The use of pain relief begins with an understanding of the several problems involved and leads finally to a selected program or pain relief technique.
4. As practicing physicians it behooves us well to evaluate our own facilities, both hospital and personnel, before deciding upon an obstetrical anesthesia method.
5. After a technique suitable to our requirements and facilities has been selected, it must then be learned. Do not switch from one technique to another willy-nilly.
6. Since no technique for obstetrical pain relief is entirely satisfactory, don't be hasty in throwing overboard, without trial, any carefully selected relief program.
7. Finally, remember that faulty obstetric judgment can invalidate any system for pain relief. With good obstetric judgment most acceptable plans for pain relief will give satisfactory results during labor.

DOCTORS DRAFT

The doctors who registered in the special draft of October 16, 1950, have almost all been processed. Of those examined in the Fifth Army Area, to which Michigan belongs, 24.88 per cent were rejected. In the Second Army Area, Washington, D. C., 32 per cent were rejected. The average for the whole United States is 21.8 per cent. Eighteen per cent of dentists were rejected and 12.6 per cent of veterinarians.

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Alabama	2,192	New Mexico	504
Arizona	802	New York	30,212
Arkansas	1,665	North Carolina	3,275
California	16,668	North Dakota	475
Colorado	2,185	Ohio	9,883
Connecticut	3,275	Oklahoma	2,164
Delaware	429	Oregon	1,802
District of Columbia.....	2,464	Pennsylvania	14,207
Florida	3,025	Rhode Island	992
Georgia	3,031	South Carolina	1,476
Idaho	484	South Dakota	492
Illinois	12,764	Tennessee	3,113
Indiana	4,307	Texas	7,724
Iowa	2,890	Utah	841
Kansas	2,039	Vermont	569
Kentucky	2,527	Virginia	3,213
Louisiana	2,913	Washington	2,714
Maine	973	West Virginia	1,753
Maryland	3,445	Wisconsin	3,696
Massachusetts	8,688	Wyoming	247
Michigan	6,937	Total in U. S.....	201,277
Minnesota	4,117	Alaska	69
Mississippi	1,457	Canal Zone, R. of P.....	165
Missouri	5,074	Hawaii	489
Montana	559	Puerto Rico	668
Nebraska	1,581	Guam, Virgin Islands.....	14
Nevada	199	Total	1,406
New Hampshire	734		

JANUARY, 1951

97

Say you saw it in the Journal of the Michigan State Medical Society

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

ADVANCES IN INTERNAL MEDICINE. Editors: William Dock, M.D., Long Island College of Medicine, Brooklyn, N. Y., I. Snapper, M.D., The Mount Sinai Hospital, New York, N. Y. Associate Editors: Tinsley R. Harrison, M.D., Medical College of Alabama, Birmingham, Ala., Chester S. Keefer, M.D., Evans Memorial and Massachusetts Memorial Hospitals, Boston, Mass., Warfield T. Longcope, M.D., Cornhill Farm, Lee, Mass., J. Murray Steele, M.D., Goldwater Memorial Hospital, New York University Division, Welfare Island, N. Y. Volume IV. Chicago: The Year Book Publishers, Inc., 1950. Price, \$10.00.

This book limits itself to a covering of nine subjects that have been selected as especially noteworthy during the past year. As such, they are completely and excellently covered by fourteen of the foremost authorities in their fields. The chapters are entitled Nitrogen Mustards in the Treatment of Neoplastic Disease, Use of Radioactive Isotopes in Medicine, Brucellosis, Advances in the Neuromuscular Disorders, Use of Sodium Depletion in Therapy, Clinical Use of Anticoagulants, Hepatitis and Cirrhosis of the Liver, Hepatic Tests, and the Vascular Physiology of Hypertension.

The bibliography on each discussion is very large, thereby giving adequate reference sources to those desiring it. The format is good and the composition makes good reading; the illustrations are excellent and adequate although relatively few in number. For the conditions

covered, this is a most excellent book and can be heartily recommended to anyone interested in the field of medicine.

G.W.S.

PATHOLOGIC PHYSIOLOGY: MECHANISMS OF DISEASE. Edited by William A. Sodeman, M.D., F.A.C.P., The William Henderson Professor of the Prevention of Tropical and Semitropical Diseases, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana; Consultant in Medicine, U. S. Marine Hospital at New Orleans. Illustrated. Philadelphia: W. B. Saunders Co., 1950.

Books similar to this, compiled by twenty-five collaborators writing with authority on their particular subject, command general medical respect. It is well edited, and one feels that the policy of producing a single volume, written by a number of authors, is receiving increasing and merited recognition. The value of this treatise stems from two sources:

First, it gives the physician the factual, or the current consensus from the theoretical standpoint, information explaining the appearance of certain symptoms, and thus establishes an understandable correlation between the clinical course of the disease and the physiopathological changes that are taking place.

Secondly, since it is written by a number of authors, the time consumed in preparation is considerably less than if it were written by one man; therefore, it provides an up-to-the-minute résumé of the progress in the various fields of medicine ranging from hematology to water balance, and thus parallels the usefulness of the various specialty year books. The chapter on hematology

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by Castle and that on the diseases of the joints by Freyberg are excellent examples.

The book is strongly recommended both as a reference book and as a medium to keep abreast of medical progress.

A.A.H.

EXHIBITIONISM. By N. K. Rickles, B.S., M.D., Fellow of the American Psychiatric Association, Diplomate of the American Board of Psychiatry and Neurology, Senior Consultant at the Veterans Administration Center, Los Angeles, Consultant in Psychiatry to the Office of the Surgeon General, Medical Department, United States Army, and Director of the Psychiatric Center of Seattle. Philadelphia: J. B. Lippincott Co., 1950. Price \$5.00.

This book is a long overdue treatise on a subject that has been greatly ignored and misunderstood. From the author's viewpoint there have been gross errors in the approach and management of exhibitionism. He presents theories of the cause and concepts of the involved psychopathology. He classifies the exhibitionist as a compulsive neurotic who feels forced to do something that he does not really like and prefers to suffer for an antisocial act rather than to allow the more socially ostracized, incest wish to become manifest. Exhibitionism is a purely defensive outburst. True exhibitionists seldom, if ever, go beyond the simple act of exposure. They make no effort to attack or molest, and as a result, they are not actually dangerous to society. He believes that they need psychotherapy and feels that the situation could be handled better and more economically if the agencies, designated by society to deal with it, would adopt a mature and scientific attitude.—G.K.S.

CEREBRAL PALSY. By John F. Pohl, M.D., Orthopedic Surgeon, Michael Dowling School for Crippled Children, Minneapolis, Minnesota. St. Paul, Minn.: Bruce Publishing Co., 1950. Price \$5.00.

The author and publisher can be congratulated on editing such an excellent treatise. Authorities have estimated that there are approximately 500,000 cases of all ages in this country and 10,000 new victims yearly; therefore, it appears important that the general medical man be more familiar with this condition. This small volume is replete with photographic illustrations in order to demonstrate and carry out a thorough plan of treatment in speech, medical and surgical methods of treatment, relaxation and pattern training programs. There are also chapters on speech correction and occupational therapy.

This book may be unqualifiedly recommended to the profession, and, furthermore, should prove to be of great benefit to the more intelligent parents of spastics.

G.K.S.

A TEXTBOOK OF X-RAY DIAGNOSIS. By British Authors, in four volumes. Second edition. Edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., Director, X-ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., Director, X-ray Department, Westminster Hospital, Radiologist, Royal Chest Hospital, London. Volume 3 with 698 illustrations. Philadelphia: W. B. Saunders Co., 1950. Price \$10.00.

This second edition is a sparkling improvement, if possible, on the memorable first edition. Concerning the abdomen, it is a full reference for the specialist and a

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(Continued from Page 65)

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